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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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Between Ourselves

Something a little different in the "series form" of articles is presented this month. Customarily in these series we have an article by a doctor, giving detailed information regarding a specific disease. An institutional nurse—usually the head nurse or supervisor who sees patients in hospital suffering from the disease in question—explains the essentials of nursing care. Wherever possible, a public health nurse describes the community aspects and implications.

This month's symposium gives prominence to some of the ***newer pharmaceutical products*** that are being used. The article by **Dr. Hans Selye** deals with cause and effect rather than any specific drug. His material is based upon the summary of an address given before the World Medical Association at its fourth Plenary Meeting in New York, October 18, 1950.

If you would read **Agnes Campbell's** brief story next, you will have a better picture of the enormous though very interesting task of the nurses in the hospitals at Humboldt and North Battleford, Saskatchewan. As Miss Campbell points out, these are only two of the several studies that were made. None of the others is available for publication at this time.

Frances Gibson worked on her paper, describing ***ACTH,*** when she was in Chicago. **Gladys Hartley** reveals the necessity for careful observation of the patient receiving ***Cortisone.***

* * *

In recent months there has been some startling and disturbing publicity given to the incidence of ***drug addiction,*** particularly among young people. The way in which this habit undermines the health and capacity for sustained work is well known. Perhaps less familiar is the treatment that is necessary to break the vicious hold that drug addiction has over its victims. The study that **Jessie MacKay** has prepared shows clearly that it calls for all the skill and persistence a nurse may possess to assist in salvaging the life of an addict and start him along the road to rehabilitation.

* * *

The Canadian Nurses' Association was represented at the 1951 meeting of the ***Grand Council of the International Council of Nurses*** by our president and general secretary. **Helen G. McArthur** has combined her New Year's message with a review of the accomplishments of the I.C.N. over a broad span of years. **Gertrude M. Hall** has extracted the meat from the numerous reports that were presented, for your information. Because it touches upon a universal problem of concern to all nurses, **Mrs. Bethina A. Bennett's** review of the causes of the increased demand for nursing service, and possible action to meet this demand, has been printed in full.

Our ***cover picture*** this month reproduces one of the many photographs taken at the civic reception in Brussels. Pictured, from left to right, are: MRS. S. THORVALDSSON, Iceland; MISS G. ARNETZ, Norway; MISS G. HÖJER, Sweden, president of the I.C.N.; MISS H. MCARTHUR. Other photographs are included with the guest editorial.

* * *

Volume 48 of The Canadian Nurse begins with this issue. At the rate that time speeds along, it will not be very long before we are celebrating our Golden Anniversary. They were a small, courageous band of nurses who launched the first issue away back in March, 1905.

Through all these years our *Journal* has striven to bring to the nurses of Canada competent reports on the progress of our profession, its endeavors to serve the people, a review of its shortcomings and its successes. This year, the May issue will be devoted largely to the reports prepared for presentation at the forthcoming ***Biennial Convention.*** The Executive Committee is making provision for the translation into French of all the major reports. These will be incorporated into the May issue also.

* * *

The Journal staff extends hearty good wishes to the thousands of nurses in Canada and in the 62 other countries throughout the world who will be reading these words. May your work prosper abundantly! May you personally experience the joy of achieving the goals that you set for yourself!

Happy New Year!

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

BENZODIOXANE

Manufacturer—Poulenc Limited, Montreal.

Description—Hydrochloride of piperidylmethyl benzodioxane, adrenergic blocking substance which exerts an inhibiting action on structures innervated by the sympathetic nervous system; it reverses the augmentor responses to adrenalin but, except in very large doses, does not depress peripheral sympathetic nervous system responses.

Use—Diagnosis of epinephrine-producing tumors (pheochromocytomas or paraganglio-mas).

LUSAN

Manufacturer—The J. F. Hartz Co. Ltd., Toronto.

Description—A safe solvent for removal of blood and tissue from surgical instruments and operating room apparatus. Suitable for hard water districts as does not precipitate calcium or magnesium.

MATUREX Non-Ferrous

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—A potent combination of hematopoietic factors, a similar formula to "Maturex" Capsules but without iron. Each dry-powder capsule contains: Vitamin B_{12} 10 mcgm.; Desiccated stomach tissue 250 mgm.; Folic acid 0.67 mgm.; Ascorbic acid 50 mgm.; Liver extract equivalent to 1 gm. fresh liver.

Indications—In the adjunctive and maintenance treatment of macrocytic hyperchromic anemias including Addisonian pernicious anemia, macrocytic anemia associated with sprue, pellagra, gastrointestinal dysfunction, and old age.

Administration—The suggested dosage is one capsule 3 times daily after meals.

MUMPS VACCINE

Manufacturer—Lederle Laboratories Division, North American Cyanamid Ltd., Montreal.

Description—Prepared from allantoic fluid of infected chick embryo, preserved with formaldehyde 0.05% and sodium ethyl mercuri-thiosalicylate 1:10,000.

Indications—Immunization against mumps where such is desirable.

Administration—2 injections of 1.0 cc., subcutaneously or intramuscularly, with interval of 1 to 4 weeks between injections. Contraindicated in persons allergic to egg.

How Supplied—2-cc. vials and 10-cc. vials. 18 months dating.

PROPYL-THYRACIL

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Each compressed tablet contains 100 mgm. of Propyl-Thyracil (propyl-thiouracil "Frosst").

Indications—1. Preoperative preparation of thyrotoxic patients. 2. Medical treatment of thyrotoxicosis. 3. Treatment of thyrotoxicosis during pregnancy. 4. Treatment of angina pectoris. Untoward effects are infrequent but caution should not be relaxed for their recognition.

Administration—In thyrotoxicosis of marked severity, 300 mgm. in divided doses daily until remission is attained. In some patients 150 mgm. daily may be sufficient to bring about remission. The dose should then be reduced until the maintenance dose is found which may be as little as 25-50 mgm. daily.

DIUCARBYN SODIUM

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—Mercaptomerin sodium (disodium salt of N-(2-carboxymethylmercapto-mercuri-beta-methoxy) propylcamphoramic acid), water-soluble mercurial diuretic.

Indications—Edema due to heart, kidney and liver disease and, generally, wherever diuretic therapy is indicated. Contraindicated in advanced chronic nephritis and acute renal disease. Sodium chloride intake should not be restricted too drastically.

Administration—Suggested range of dosage, 0.5 to 2 cc. subcutaneously.

How Supplied—*Hospital Package:* Vial of 4.2 gm. powder to be reconstituted with 30 cc. sterile water.

ASTEROL (DIHYDROCHLORIDE)

Manufacturer—Hoffmann-La Roche Limited, Montreal.

Description—Potent, well-tolerated antifungal agent. Chemically, it is the dihydrochloride of 2-dimethyl-amino-6-(beta-diethylaminoethoxy)-benzothiazole. The drug is characterized by good diffusibility and keratolytic activity.

Indications—Fungus infections of the skin, the hair and the nails, particularly ringworm of the scalp, athlete's foot, ringworm of the body and other persistent fungal infections.

Administration—Either the ointment or the tincture may be applied once or twice daily to the affected area. The tincture is applied either with an atomizer or sprayer, or with a cotton pledget. The dusting powder should be sprinkled into shoes, stockings, or socks for the prevention of recurrence of athlete's foot.

DILAXOL DISKS

Manufacturer—E. B. Shuttleworth Chemical Co., Toronto.

Description—Each compressed disk contains: Bismuth Subgallate, Magnesium Trisilicate, Magnesium Carbonate, Calcium Carbonate, Kaolin and Diastase.

Indications—Dyspepsia, hyperacidity, nausea, and other gastrointestinal disorders.

Administration—One to be dissolved in mouth, or chewed, as often as required.

FENOCYLIN

Manufacturer—Ciba Company Ltd., Montreal.

Description—Each tablet represents 1 mgm. laevo-7-methyl-bisdehydroisynolic acid, synthetic estrogen.

Indications—Menopausal symptoms.

Administration—Orally.

PALACILLIN "3" TABLETS

Manufacturer—Bristol Laboratories of Canada Limited, Montreal.

Description—Each tablet contains: 100,000 I.U. of Penicillin G. Potassium and 0.17 gm. of each of: Sulfadiazine, Sulfamerazine and Sulfamethazine.

Indications—Many infections in children and adults in which combined therapy with oral penicillin and sulfonamides is indicated.

Administration—In order to promote the absorption of the contained penicillin, should be administerred not less than one hour before or two to three hours after eating.

LAXATONE

Manufacturer—The British Drug Houses (Canada) Limited, Toronto.

Description—Each tablet contains methyl cellulose 2½ grains; sodium carboxymethylcellulose 5 grains.

Indications—A bulk-forming inert medicinal agent which is not absorbed by the intestinal mucosa, for use in the correction of chronic constipation.

Administration—Three tablets three times daily. When satisfactory bowel action is attained, dosage is gradually reduced.

CHLOROMYCETIN OPHTHALMIC OINTMENT

Manufacturer—Parke, Davis & Company Ltd., Walkerville, Ont.

Description—A special petrolatum ointment base containing 1% of Chloromycetin (chloramphenicol, Parke-Davis), in dispensing tubes.

Indications—High local concentrations of Chloromycetin may be obtained with the use of Chloromycetin Ophthalmic Ointment, 1%. As the antibacterial spectrum of Chloromycetin includes the majority of eye pathogens, the ointment may be used either prophylactically following surgery or removal of foreign bodies, or in treatment of certain forms of bacterial conjunctivitis and other eye conditions.

METHOSTAN

Manufacturer—Schering Corporation Ltd., Montreal.

Description—Brand of Methandriol (Methylandrostenediol), a non-virilizing steroid related to methyltestosterone.

Indications—In retarded growth and constitutional diseases accompanied by protein wastage.

Administration—*Adults:* 10 to 40 mgm. daily. *Children:* 5 to 10 mgm. daily or less frequently.

GYNETONE

Manufacturer—Schering Corporation Limited, Montreal.

Description—*Tablets:* each contains 1 mg. Ostradiol and 10 mg. Methyltestosterone. *Injection:* each cc. contains 1 mg. Ostradiol Benzoate and 20 mg. Testosterone Propionate.

Indications—Menopausal symptoms. Provides single dose form of oestrogenic and androgenic steroids in typically suitable ratio.

DIBISTINE

Manufacturer—Ciba Company Ltd., Montreal.

Description—A synergistic combination of two antihistaminics. Each coated tablet contains 25 mg. Pyribenzamine and 50 mg. Antistine.

Indications—All conditions of allergic origin: allergic rhinitis, urticaria, eczematous dermatitis, drug reactions, contact dermatitis, allergic cough, bronchial asthma, etc.

Administration—*Adults and children over 12* — One tablet four times daily after meals. If symptoms controlled, reduce to one tablet three times daily. As many as 8 tablets daily may be given. *Children 6-12:* 50% of adult dose. *Children 2-5:* 33% of adult dose.

CHLOROMYCETIN CREAM

Manufacturer—Parke, Davis & Co. Ltd., Walkerville, Ont.

Description—Chloromycetin (chloramphenicol, Parke, Davis), 1% incorporated in a smooth, non-irritating, water-miscible cream for topical use.

Indications—Useful in many superficial infections and dermatological conditions complicated by secondary infections such as superficial pyodermas, impetigo, acute folliculitis, seborrhea-like streptodermis, and infectious eczematoid dermatitis; also for dressing minor surgical wounds.

THIOSULFIL

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—"Thiosulfil" is the most soluble of all sulfonamides. Each oval, white scored tablet contains 0.25 gm. Sulfamethylthiodiazole.

Indications—General urinary tract infections due to E. coli, organisms of the coliform type, B. proteus, B. pyocyaneus, etc.

Administration—The suggested dosage for adults is 1 to 2 tablets five or six times daily and for children ½ to 1 tablet five or six times daily.

SORLA-BILEIN Capsules

Manufacturer—Abbott Laboratories Ltd., Montreal.

Description—Each capsule contains:
Sorlate (Polysorbate 80, Abbott) 0.4 gm.; Bilein (Ox Bile dried, purified, Abbott) 30 mg.; Dehydrocholic acid, 30 mg.

Indications—Functional gallbladder disease.

Administration—Adults, 12 capsules daily in equal divided doses with meals.

Word Game

Many of our readers have wondered why we do not have a crossword puzzle in each issue as a form of relaxation after a strenuous day's work. The answer lies in our own inadequacy in constructing them.

As an alternative form of mental gymnastics we recommend this word game. We will run them for a few months to see how you, the readers, like them.

The idea in this form of word construction is to move from square to square in any direction—up or down, across or diagonally—using each letter only as often as it appears in the diagram. For example, a fine, long word that can be made is C-H-A-P-E-R-O-N. No words of less than four letters count in this game, nor do proper names nor plural forms when you have used the singular. Try your hand at it and see if you can beat our total of 179. You will find our list of words further back in this issue. All of them are to be found in the dictionary. Ready now—away you go! (*See page 81 for our list*)

F	G	N	W	D
Q	L	O	R	B
U	I	T	E	P
J	S	M	A	K
Z	E	H	C	Y

The CANADIAN NURSE

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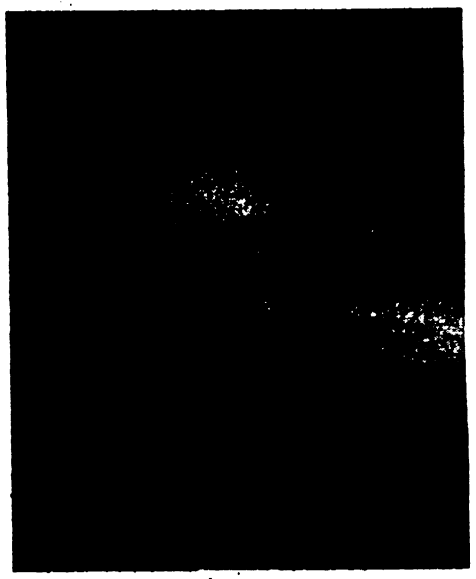
Achievement

"SO FAR AS I am an individual, my country is Canada; but so far as I am a nurse, I am a citizen of the world." This paraphrase of the words of a Roman philosopher sums up the impact of a meeting of the International Council of Nurses on one Canadian nurse. It is said in wonder and humility. It accepts the fact that participation confers both privileges and responsibilities; and recognizes that it is on the responsibilities that nurses, whether individually or as organized groups, must concentrate.

We are all inclined to feel exasperated by our own impotence in the face of today's world situation. We have days when we feel there is little hope. Yet, what better example could we have than our own profession to prove that we need not stand idly by, hopelessly wringing our hands. Nurses do know that right-minded people, with goodwill, honest purpose and effort, can achieve the goal of world citizenship.

Over 50 years ago nurses were the first group of professional women to organize themselves internationally. Our founders were confident that nurses, if suitably organized, had a great and necessary part to play in international affairs. Events of the last half century have justified the confidence of the pioneer women from



Ballard-Jarrett, Toronto

HELEN G. MCARTHUR

many countries who joined together in 1899 to form the Committee to carry this inspired idea into practical effect. It has earned and retained the support and loyalty of nurses the world over. It has survived two world wars while continuing to build up bonds of friendship and fellowship. It has played a part in the cause of peace and goodwill. At the last Board of Directors' meeting in Brussels, the President, Miss Gerda Höjer, stressed the fact that the International Council of Nurses is well recognized by authorities, internationally and nationally. Its advice and help are frequently sought. Most recently, the World Health Organization emphasized the importance of raising the status of the nursing profession *as a means of improving the status of women all over the world*. Surely this is a world citizenship—a world citizenship built on professional integrity.

The executive secretary, International Council of Nurses, Miss Daisy Bridges, has interpreted this oneness of the nurses of the world as follows:

> But we nurses from whatever country we come are privileged to have a common language. It is not necessarily set down in words or phrases. It does not necessarily have to be spoken. It is the language of a common purpose and of sympathy and understanding, and all of us who are linked in a great federation such as our International Council of Nurses do not necessarily have to express ourselves in words to know that our motives will be understood.

It is difficult to provide an opportunity for each individual nurse to know and understand the reality of this international communication. We must use every means at our disposal. Canadian nurses are becoming better known throughout the world through the work of the Canadian Nurses' Association War Memorial Committee. While visiting Europe this summer, I entered many nursing offices and libraries in six countries. A common sight was *The Canadian Nurse* on the desk, obviously read. Frequently I was brought up to date on affairs in my own country.

How shall we learn about nurses in other countries? *The International Nursing Bulletin* can give us a glimpse if we read it often and well. Other reading material is available if we search it out. Nurses from other lands are in our country. If we stop talking about ourselves once in awhile, they will share their experiences.

Distances are great on this continent and we cannot visit our fellow nurses in other countries as often as European nurses move back and forth on their continent. However, we can try to join in, at the time of the next I.C.N. Quadrennial Congress to be held in Brazil in 1953. The Brazilian nurses are exploring every possibility of inexpensive group travel and reasonable accommodation in order that nurses from the member countries may avail themselves of the opportunity of visiting one of the most fascinating cities of the world as well as participating in one of the most satisfying professional experiences available to us. However, more important still is the role played by each nurse in her own sphere of activity. The privilege of taking our place in international affairs becomes ours only in so far as every nurse gives her active support to her professional organization—locally, nationally, and internationally.

If nurses believe in world citizenship for themselves, it can come to all women. Yes, and further yet, for, in the words of Miss G. Höjer, president of the I.C.N.—

> At last men in power are beginning to understand that, instead of losing their power, they will increase it by taking advantage of help from the half of the world represented by women in different professions.

One cannot return from a meeting of the International Council of Nurses without a strong ray of hope in her heart for the future. At this New Year, as we greet each other and join to send our sincere good wishes to our fellow nurses around the world, let us resolve to turn our heritage into achievement and pray together—

"On earth peace, good will toward men."

HELEN G. MCARTHUR
President, C.N.A.

Entertained by the Lord Mayor

Far left—GRACE FAIRLEY, GERDA HOJER

Some of the participants at the Brussels meeting

Canada Year Book

Frequent bits of information about this Canada of ours are given from time to time over the radio. The source of the facts is given as the "Dominion Bureau of Statistics." Available now for the sum of *$3.00* is the published report from the Bureau which contains an amazing compilation of data relating to our general economic and social conditions.

There are, of course, statistics on the routine things one expects from such a bureau—births, marriages, deaths, disease incidence, etc. But that is only a small fraction of the information that may be gleaned from this informative compendium. For instance, the chapter on the major soil zones explains most clearly why certain areas—altogether about 65 per cent of the country—are unfit for agriculture, a fact that puts definite limits on the population that can be supported. The problems of supplying electricity for industrial purposes in those non-arable areas is dealt with in another chapter.

Broaden your personal knowledge of the potentialities of Canada by dipping deeply into this fascinating volume.

Remember the steam kettle. Though it is up to its neck in hot water, it still sings.

The General-Adaptation-Syndrome and the Diseases of Adaptation

HANS SELYE, M.D.

EXPERIMENTS ON VARIOUS species of experimental animals showed us that the organism responds in a stereotypical manner to a variety of widely different agents, such as: infections, intoxications, trauma, nervous strain, heat, cold, muscular fatigue or x-irradiation. The specific actions of all these agents are quite different. Their only common feature is that they place the body in a state of stress. Hence, we concluded that the stereotypical response—which is superimposed upon all specific effects—represents a *reaction to stress as such*.

The first-noticed manifestations of this stress-response were: *adreno-cortical enlargement*, with histological signs of hyperactivity, *thymico-lymphatic involution*, with certain concomitant changes in the blood-count and *gastrointestinal ulcers*, often accompanied by other manifestations of *damage or "shock."* We were struck by the fact that, while during this reaction all the organs of the body show involutional or degenerative changes, the adrenal cortex actually seems to flourish on stress. We suspected this adrenal response to play a useful part in a non-specific adaptive reaction, which we visualized as a "call to arms" of the body's defence forces and named the *"alarm-reaction."*[1]

Later investigations revealed that the alarm-reaction is merely the first stage of a much more prolonged *general-adaptation-syndrome*. The latter comprises three distinct stages, namely: the *alarm-reaction* in which adaptation has not yet been acquired, the *stage of resistance* in which adaptation is optimal and, finally, the *stage of exhaustion* in which the acquired adaptation is lost again.

The experimental analysis of the mechanism of this syndrome was carried out as follows:

Animals were *adrenalectomized* and then exposed to stress or agents. This showed us that in the absence of the adrenals stress can no longer cause thymico-lymphatic involution or characteristic blood-count changes.

When adrenalectomized animals were treated with the impure *cortical extracts* available at that time, it became evident that thymico-lymphatic involution and blood-count changes could be produced by adrenal hormones even in the absence of the adrenals. The latter therefore were considered to be indirect results of stress mediated by corticoids.

On the other hand, the gastrointestinal ulcers and other manifestations of pure damage were actually more severe in adrenalectomized than in intact animals and could be lessened by treatment with cortical extracts. It was concluded that these lesions are not mediated by the adrenal and are combatted by an adequate adrenocortical response to stress.[2]

In 1937, we found that *hypophysectomy* prevents the adrenal response during the alarm-reaction and concluded that stress stimulates the cortex through the adrenocorticotrophic hormone ACTH.[3]

Later, when pure cortical steroids became available, we could show that administration of *mineralo-corticoids* (such as desoxycorticosterone) produce experimental replicas of the so-called hypertensive and rheumatic diseases — notably, nephrosclerosis, hypertension, vascular lesions (especially periarteritis nodosa and hyaline necrosis of arterioles[4]) as well as arthritic changes resembling, in acute experiments, those of rheumatic fever and after chronic treatment those of rheumatoid arthritis[5]. Yet, even very high doses of mineralo-corticoids did not induce any noteworthy thymico-lymphatic or blood-count changes.

Significantly, exposure of animals to non-specific stress or agents (e.g., cold) produced marked adreno-cortical enlargement and organ changes very similar to those elicited by the administration of mineralo-corticoids.[6]

Gluco-corticoids, (such as cortisone) on the other hand, were highly potent in causing thymico-lymphatic involution and in eliciting the characteristic blood-count changes of the alarm-reaction. Furthermore, they tended to inhibit the hypertensive and rheumatic changes which can be elicited in animals by mineralo-corticoids. Thus, in many respects, the two types of corticoid hormones antagonize each other.[7, 8]

Inflammatory granulomas, especially those produced in the vicinity of joints by the local application of irritants (e.g., formalin, mustard powder) as well as certain allergic reactions, are also aggravated by mineralo- and prevented by gluco-corticoids. Apparently the response of the adrenal cortex is most important not only in defence against systemic stress (affecting the whole organism), but also in the manifold topical defence reactions which occur upon exposure to *local stress* (e.g., bacterial or chemical irritants, responses of a "shock organ" to an allergen).[8, 9]

It was also observed that *crude anterior pituitary extracts*[10] or lyophilized anterior pituitary tissue (LAP[7]) duplicate the above mentioned actions of mineralo-corticoids upon the cardiovascular system, the blood-pressure and the kidneys. The hypophyseal preparations, which we used, were definitely corticotrophic, in that they enlarged the adrenal cortex, but they were also rich in the so-called "growth hormone" or somatotrophic hormone (STH). As soon as we were able to obtain purified *ACTH*, it became evident that the above mentioned pathogenic actions of the crude anterior pituitary preparations could not be due to their ACTH content, since even the highest tolerable doses of the latter hormone failed to duplicate these effects. On the other hand, overdosage with pure *STH* caused cardiovascular and renal lesions, identical with those previously observed in animals treated with mineralo-corticoids. It was concluded that the above mentioned actions of our crude anterior pituitary preparations was due to their STH content. It remains to be seen to what extent STH acts indirectly, by stimulating the mineralo-corticoid production of the adrenal cortex or, directly, by sensitizing the peripheral tissues to mineralo-corticoids. Preliminary observations suggest that both these mechanisms are implicated.[11]

We conclude that the pathogenicity of many systemic and local irritants depends largely upon the function of the hypophysis-adreno-cortical system. The latter may either enhance or inhibit the body's defence reactions against stressor agents and we think that derailment of this adaptive mechanism is the principal factor in the production of certain maladies which we therefore consider to be essentially *diseases of adaptation*.

Among the *derailments of the general-adaptation-syndrome which may cause disease*, the following are particularly important:

1. An absolute excess or deficiency in the amount of corticoids and STH produced during stress.

2. A disproportion in the relative secretion during stress, of ACTH and gluco-corticoids on the one hand, and of STH and of mineralo-corticoids on the other.

3. Production by stress of metabolic derangements, which abnormally alter the target-organ response to STH, ACTH or corticoids (through the phenomenon of "conditioning").

4. Finally, we must not forget that although the hypophysis-adrenal mechanism plays a prominent role in the general-adaptation-syndrome, other organs which participate in the latter (e.g., nervous system, liver, kidney) may also respond abnormally and become the cause of disease

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during adaptation to stress.

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A more detailed analysis of this concept, with an extensive survey of the pertinent literature, has been compiled in our monograph "Stress" upon which this synopsis is based.

Saskatchewan Institutional Nurses Study New Drugs

AGNES CAMPBELL

AT THE OPENING of the 1950-51 season, Miss Violet Parker, as secretary of the provincial committee on Institutional Nursing, and I, as chairman, invited suggestions from institutional nurses on projects that might be undertaken by the Chapter Committees during the winter months. The most popular suggestion received was for a study of new drugs. Many of the nurses had found themselves handling drugs about which they knew very little as to source, composition, action, side effects, etc. We wrote to all the Chapter Committees on Institutional Nursing, outlining the project and giving them some headings under which to collect their material.

In due course the committees learned that national research institutions do not send out information to nursing groups and that, in many cases, the best sources of reliable information were articles in the columns of current nursing, medical, and pharmaceutical periodicals. Most of these articles were written by recognized authorities and based on carefully kept records. In the larger centres the committees found guest speakers and films from pharmaceutical houses good sources of information. To the material collected they added their own observations.

Near the end of the season we sent out another letter and the material began coming in. We were delighted with the response. Practically all of the chapters sent reports. Some of the articles came in essay form and we felt were worthy of publication. In some cases more than one chapter reported on a particular drug. In the final report all were reduced to a simple form, one article for each drug, for easy reference. They filled eight closely typewritten foolscap sheets. These were mimeographed and distributed to the institutional nurses when they met in committee at the provincial convention in Regina last May. They took the reports back to the other members of their committee that they might share in the result of their joint effort.

We realize that a week rarely passes without a new drug appearing on hospital wards for nurses to administer and that still newer drugs will supersede some that were included in our 1950-51 study. However, having investigated drugs for the study the nurses will have learned where to get reliable information on the new products they are using or in which they are interested. They will be able to render better service to their patients and the doctors with whom they work, to say nothing of the personal satisfaction to be derived from the knowledge gained.

Complying with the request of Miss Mary E. Macfarland, chairman of the Committee on Institutional Nursing, Canadian Nurses' Association, complete copies of the drug study will be made available to all the provincial nurses' offices. The two sections of the material published herewith show the calibre of the material.

Miss Campbell, who is chairman of the Committee on Institutional Nursing, Saskatchewan Registered Nurses' Association, is superintendent of nurses at the Prince Albert Sanatorium.

Antibiotics

THE WORD "antibiotic" is derived from the Greek words "anti", and "bios" and means *against life.* It was originally coined in 1942 to indicate antagonism between organisms, resulting in an undesirable effect upon one of them. It is not really a new discovery but the impetus given this particular field of science by the discovery of penicillin has brought to light most of the world's literature concerning antagonism between organisms. The term "antibiotic" has been more or less restricted to those substances isolated from the lower plants such as bacteria and fungi. If this were not the case, countless materials would have to be included that have proven deleterious to the existence of the pathogens of man. The definition of an antibiotic cannot be rigidly laid down, nor can it be rigidly interpreted. The suggestions of Baron are as follows:

> An antibiotic is a product of metabolism which antagonizes the growth and/or survival of one or more species of microorganisms and is effective in low concentration.

As early as 1877, Pasteur and Joubert observed that certain airborne organisms inhibited the growth of the anthrax bacillus. In 1899 Emmerich and Loew suggested the pyocyanase from *Pseudomonas aeruginosa* could be employed to treat anthrax and diphtheria. Today, the name Alexander Fleming is a byword in scientific circles following his observation in 1929 that a species of penicillium growing on a culture plate inhibited the growth of *Staphylococcus*

Prepared by the nurses from the Humboldt Chapter, Saskatchewan Registered Nurses' Association, as part of the "Study of New Drugs" carried on by the Institutional Committee, S.R.N.A.

aureus as did also dilutions of a nutrient broth on which the penicillium had grown. He named the substance "Penicillum" and suggested its possible use as an antibacterial agent.

Dubos in 1939 investigated an antibacterial substance secured from the filtrates of cultures of a soil organism, *Bacillus brevis*, and isolated Tyrothricin which proved effective against a variety of pathogens. Owing to its toxicity upon parenteral administration, its use was limited, but it served to engender further research in the field of antibiotics. In 1940, the Oxford workers demonstrated the outstanding activity of penicillin against certain animal infections and the complete lack of toxicity. Waksman and co-workers in 1944 isolated *Streptomyces griseus* and a valuable antibiotic was made available to the medical and pharmaceutical professions.

Since these initial observations, thousands of organisms have been investigated for possible antibiotic substances. While many are too toxic for human use, those few that are effective are of inestimable value in the realm of infectious diseases. Table I lists five antibiotics frequently encountered on the market today.

Production

The majority of the antibiotics are produced by deep culture fermentation in tanks with a capacity of from a few gallons to 20,000 gallons. The growth medium is of prime importance and factors such as temperature, pH, oxygen tension, and type of container have a great bearing on the outcome of the biosynthesis. The fermentation medium is freed from mycelial debris and extracted by suitable methods such as adsorption on charcoal and subsequent elution or solvent extraction under varying conditions of acidity or alkalinity. The substance can be secured in the powdered form by evaporation and vacuum techniques but one of the most useful procedures is that of freeze-drying. The antibiotic in solution is placed in bulk containers or in the final marketable container and rapidly frozen at a temperature of −50 °C., transferred to vacuum desiccators, and evaporated to dryness.

Range of Activity and Therapeutics

In a similar manner to the physical usage of the term "spectrum," so is the range of antibiotic activity indicated by means of the same word. For example, penicillin has been found effective principally against certain Gram-positive organisms; streptomycin is effective against certain Gram-negative organisms and other antibiotics are effective against a wide range of both Gram-negative and Gram-positive organisms, viruses and rickettsii. The spectrum of each antibiotic is very large since much of the testing has been performed in a test tube (in vitro) and the results recorded as such but the final criterion is the manner in which it behaves in the clinic. The selection of the suitable antibiotic some four years ago was a comparatively simple matter but today careful attention must be given to the choice and, in certain instances, combinations must be used. The physician must take into account the effectiveness, toxicity, ease of administration, cost, etc., before making his selection. An antibiotic to be useful should satisfy the following criteria:

1. It must kill or suppress the growth of a wide variety of organisms.
2. There should be no damaging action on the body cells.
3. It must be readily absorbed into the blood stream.
4. It must be stable and effective in the body fluids.
5. There should be low toxicity and no production of variants.

There is no substance which fully meets all these requirements. The rigidity of the criteria tends to bring forward those most suitable. Table II outlines in a general way those diseases responding to treatment with the respective antibiotics and Table III the types of preparation found on the market. (*See end of article.*)

General Considerations

With the introduction of Aureomycin, Chloromycetin, and Terramycin, indications for the use of the sulphonamides are becoming more and more restricted. The sulfas are still indicated in such cases as bacillary dysentery, meningoccic meningitis, and urinary tract infections. The triple sulfonamides have been a real step forward in preventing crystalluria. Very often the physician prescribes sulfa drugs in combination with antibiotics.

A major advance in antibiotic therapy was the development of procaine penicillin. Therapeutic blood levels were originally maintained by combinations of penicillin with epinephrine, para-amino hippuric acid, benzoic acid and caronamide, all of which tended to retard absorption and prolong blood levels. This was followed by penicillin in oil with beeswax and blood levels were maintained for 12 hours with a dosage of 300,000 units. Procaine penicillin further prolongs the blood level for 24 to 48 hours and, by the incorporation of aluminum monostearate, levels have been maintained for as long as three to four days.

It will be noted from Table II that procaine penicillin and crystalline potassium penicillin are used together. This is done to give an immediate high concentration which is maintained more readily by the more slowly absorbed procaine salt. The more slowly absorbed preparations are a distinct advantage in the treatment of syphilis but are much less efficacious in acute infections where an immediate high level is necessary—as for example, enterococcic endocarditis. Penicillin-resistant organisms do develop but Staphylococcus is the only offender of any import.

Streptomycin is used principally for tuberculosis and urinary tract infections caused by *Bacillus proteus* and *Pseudomonas aeruginosa*. The latter two organisms respond very poorly to the majority of antibiotics as contrasted to the excellent response shown toward the coliaerogenes group. Streptomycin is being supplanted to some extent because of such deleterious side-effects as nausea, dizziness, impairment of hearing, and because it readily develops resistant strains of pathogenic organisms. Some investigators still express doubt as to the supposed lesser toxicity of dihydrostreptomycin sulfate.

Aureomycin, Chloromycetin, and Terramycin have very low toxicity, a broad spectrum, and show good absorption when used orally. Oral administration is one distinct advantage. None of them is really superior. They are all bacteriostatic rather than bactericidal. Terramycin resembles Aureomycin in its activity more than it does Chloromycetin. These three antibiotics are particularly effective against the rickettsii, typhoid fever, psittacosis, tularemia, lymphogranuloma venereum, and granuloma inguinale, all of which occur less frequently in Canada. Chloromycetin is especially active against typhus, typhoid and paratyphoid fevers. All the pneumonias respond very favorably to these three as do the urinary tract diseases except proteus and aeruginosa as pointed out above. Penicillin-resistant fevers call for the use of these three antibiotics. In general, it may be said that Penicillin is more effective than Aureomycin and Chloromycetin with Gram-positive organisms, and that Streptomycin is more effective than Aureomycin and Chloromycetin with Gram-negative organisms. Chloromycetin is amazingly non-toxic and produces few, if any, side reactions, save occasional nausea and vomiting. Aureomycin and Terramycin occasionally cause mild nausea, vomiting, and epigastric distress but the most common reaction is looseness of the stools.

Recent Developments

There have been many other antagonistic substances isolated from microorganisms but the majority of them are too toxic for human use. Neomycin, Viomycin, and Mycomycin are still in the experimental stages and offer hope in the treatment of tuberculosis. Antimycin A, isolated from a streptomyces species, has been found active in controlling certain insect pests and may afford protec-

tion to wool fabrics. Actibione is a by-product of Streptomycin production and packages coated with it are protected from attack by rats and mice. A combination of Aureomycin and Bacitracin has been found to attack all the organisms of each antibiotic and appears quite safe while giving a prolonged concentration. A combination of Streptomycin, Bacitracin, and Polymyxin B has been found valuable in the treatment of colitis and diarrhea.

Subtilin from *Bacillus subtilis* and Lupulon from hops appear to act as food preservatives and may lower the cost of canned goods.

The growth of chicks, turkeys, and swine has been promoted by adding vitamin B to the animal feed but Penicillin, Streptomycin, Aureomycin, and Terramycin have shown up as powerful growth stimulants greater than the use of vitamin B alone.

Penicillin with sulfadiazine or with sulfamethazine has been found valuable in the treatment of mastitis in cattle while Penicillin with wetting agents, such as zephiran or aerosolis, has been found of use in the treatment of chronic osteomyelitis.

Antibiotic therapy has come a long way and has proven immensely valuable in the modern physician's armamentarium; but there are still many diseases untouched, such as nephritis, poliomyelitis, measles, chickenpox, mumps, etc. It is an earnest hope that remedial agents for these diseases may soon be forthcoming.

Table I

Antibiotic	Source	Form and Solubility	Stability
Aureomycin	Fermentation using *Streptomyces aureofaciens*	Amphoteric but generally as the hydrochloride; soluble in water, methanol; slightly soluble in ethanol and acetone.	Dry salt stable. Aqueous solution relatively stable at pH 2.5 to 4 for two weeks with refrigeration.
Chloromycetin	Fermentation using *Streptomyces venezuelae* or synthetically.	Soluble in water, lower alcohols, propylene glycol and acetone.	Stable dry. Aqueous solution stable at pH 2-9 for one month. Refrigeration recommended.
Penicillin	Fermentation using *Penicillium chrysogenum.*	Sodium, potassium and calcium salt of penicillin G. Very soluble in water.	Dry salts stable. Very unstable in presence of moisture. Refrigeration necessary for aqueous solutions and only for one week without buffers. Maximum stability at pH 6 and enhanced by use of buffers.
Streptomycin	Fermentation using *Streptomyces griseus.*	Hydrochloride, sulphate, calcium chloride complex, dihydrostreptomycin sulfate. Soluble in water.	Dry salts. Aqueous solution reasonably stable between pH 3 to 7 for 60 days but refrigeration necessary.
Terramycin	Fermentation using *Streptomyces rimosus.*	Amphoteric but generally as the hydrochloride. Soluble in water, acetone, methanol, ethanol and propylene glycol.	Dry salt stable. Aqueous solutions reasonably stable at low pH but hydrolysis occurs.

Table II

General Indications for the Use of Antibiotics

Aureomycin

Systemic
- Amebiasis
- Brucellosis
- Bacterial endocarditis
- Gonorrhea
- *Granuloma inguinale*
- *Lymphogranuloma venereum*
- Meningitis
- Pneumococcic pneumonia
- Primary atypical pneumonia
- Peritonitis
- Psittacosis
- Q fever
- Rocky Mountain spotted fever
- Tularemia
- Typhus
- Urinary tract infections (coli-aerogenes group)
- Whooping cough
- Staphylococcic infections (Gram-positive)
- Streptococcic infections (Gram-positive)
- Syphilis
- Trachoma
- Yaws

Topical: Infections of the skin, oral cavity, and respiratory tract. Vincent's infection and inflammation of gums.

Chloromycetin

Systemic
- Bacillary dysentery
- Brucellosis
- *Granuloma inguinale*
- *Lymphogranuloma venereum*
- Peritonitis
- Primary atypical pneumonia
- Psittacosis
- Q fever
- Rocky Mountain spotted fever
- Relapsing fever
- Typhoid fever
- Typhus
- Urinary tract infections
- Whooping cough

Penicillin

Systemic
- Bacterial endocarditis
- Bacterial pneumonias.
- Gas gangrene
- Gonorrhea
- Meningococcic infections

Topical: Gram-positive and Gram-negative infections of the skin and oral cavity.

Penicillin

Injectable types (parenteral)

Streptomycin

Systemic
- Enterococcic endocarditis (with penicillin)
- Plague (Gram-negative)
- Tuberculosis
- Urinary tract infections due to Gram-negative organisms

Terramycin

Systemic
- Amebiasis
- Brucellosis
- Gonorrhea
- *Granuloma inguinale*
- *Lymphogranuloma venereum*
- Peritonitis
- Pneumococcic pneumonias
- Primary atypical pneumonia
- Typhus
- Urinary tract infections
- Whooping cough

Bacitracin

Amebiasis—internally

Principally used *topically* in ointment or powder form for treatment of infected lesions or wounds where the pathogen is generally a common Gram-positive streptococcus or staphylococcus. Acne, boils, carbuncles, abscesses are a few familiar infections.

Tyrothricin

Topically for superficial infections due to pneumococci, staphylococci, streptococci, and similar Gram-positive pathogens.

Gramicidin

Topically for superficial skin infections and wounds involving Gram-positive organisms.

Table III

Preparation of the Antibiotics

	Aqueous
Procaine penicillin G	

Procaine penicillin G and penicillin G potassium
Penicillin G potassium salt, crystalline

Oil
Sodium, potassium or calcium with beeswax
Procaine penicillin G and potassium penicillin G
Procaine penicillin G potassium with aluminum monostearate

Inhalation
Penicillin G sodium or potassium
Soluble tablets of potassium salt

Oral
Tablets of penicillin G sodium and potassium
Troches
Granules
Chewing gum
Chocolate powder
Coated tablets
Powder

Topical
Ointment
Ophthalmic ointment
Penicillin with sulfa drugs
Capsules
Vaginal suppositories
Ointments with vasoconstrictors

Streptomycin
Dihydrostreptomycin sulphate vials
Glucuronolactone and streptomycin sulphate tablets
Streptomycin calcium chloride complex
Streptomycin hydrochloride or sulphate
Streptomycin ointment

Aureomycin
Aureomycin hydrochloride capsules
Aureomycin vials with leucine diluent
Chocolate powder
Ointment (topical)
Ophthalmic ointment.
Troches

Chloromycetin
Capsules
Ophthalmic ointment

Terramycin
Capsules
Vials of the hydrochloride

Bacitracin
Powder
Troches
Tablets
Nasal preparations with ephedrine

Tyrothricin
Ointment
Cream with sulfathiazole
Nasal jelly
Lozenges
Pastilles
Solutions

Gramicidin
Ointment
Nose drops

Dicumarol

DICUMAROL IS A chemical compound with the awe-inspiring formula 3,3'-methylene-bis-(4-hydroxycoumarin). Given orally, Dicumarol provides a logical and economical approach to the treatment of disorders associated with thrombus formation or extension. It has become an important adjunct in clinical practice for treatment of such conditions as:

Pulmonary embolism (prevention).
Sudden arterial occlusion.
Prophylaxis during post-operative period.
Thrombosis promoted by local inactivity due to splints.
Thrombophlebitis.

Prepared by the nurses at Notre Dame Hospital, North Battleford, Sask., as part of the "Study of New Drugs."

While Dicumarol therapy is generally contraindicated in diseases of the liver, it has been suggested that, because of the exaggerated response of prothrombin times in patients having hepatic diseases, small doses may be useful in making the diagnosis of such disease. The use of Dicumarol in subacute bacterial endocarditis is generally not recommended, although it may find application in combating the thrombosing tendency induced by penicillin or by coagulase-positive bacteria.

Antithrombin, prothrombin, calcium, and fibrinogen are all present in the blood plasma. Thromboplastin is formed when platelets break down. Prothrombin is thought to be found in the liver and may be associated with vitamin K. The normal prothrombin time is 70-115%.

Dosage

At present Dicumarol is only available for oral administration. Soluble salts for intravenous use have not been found to be stable. Dicumarol should not be administered until the prothrombin time has been determined. Initial elevated prothrombin time, due to causes other than previous Dicumarol therapy, is a definite indication for reduction of the initial dose of Dicumarol. After the initial dose, the drug should not be administered on any day until the patient's prothrombin time for that day has been determined. The dosage should then be adjusted in accordance with the clinical and laboratory findings. It is suggested that the total daily dose be given at one time.

Following the oral administration of Dicumarol there is a latent or lag period of 24 to 48 hours, rarely as long as 72 hours, before any effect of the drug, as measured by the prothrombin time with whole plasma, is apparent. Following daily administration of the drug there is, therefore, a cumulative effect. This action will vary in different individuals and, because of this variation, optimal therapeutic effects without hemorrhage can be obtained only when dosage is individualized for each patient.

The initial dose has been estimated on the basis of 5 mgm. per kilogram of body weight (e.g., 300 mgm. for a patient weighing 132 lb.). Subsequent dosage is controlled by daily prothrombin time determinations.

Prothrombin plus Thromboplastin plus Calcium = Thrombin.

Thrombin plus Fibrinogen = Fibrin.

First day—Determine prothrombin time by the Quick method. (If this is elevated for any reason other than previous Dicumarol therapy, the dosage should be lowered.) Give one dose of 200 to 300 mgm. depending on the size and condition of the patient.

Second day—The prothrombin time is determined and interpolated into the percentage of prothrombin activity. If the prothrombin activity is more than 60%, 100 mgm. to 200 mgm. of Dicumarol are administered.

Third and each subsequent day—The drug is not administered until the result of the prothrombin time or activity for that day has been reported. No Dicumarol is given on any day that the prothrombin activity is less than 30%. If the prothrombin activity is 60% or more, 100 mgm. to 200 mgm. of the drug, determined by the patient's previous response, are administered on that day. In the event that the prothrombin activity becomes reduced below 30%, the patient should be closely observed for any evidence of hemorrhage. At the first indication of bleeding, transfusions of fresh whole blood should be given, repeated if necessary until bleeding is controlled.

With the first transfusion, a single, slow, intravenous administration of a large dose of water-soluble preparation of vitamin K may be of value. In the event of such excessive hypoprothrombinemia, the patient should be carefully examined once or twice daily and prothrombin activity determinations should be made with equal frequency until the prothrombin activity returns within the desired therapeutic range.

Prothrombin quotient:

$$\frac{\text{Normal clotting time} \times 100}{\text{Clotting time of patient's blood}}$$

A number of patients have been maintained on Dicumarol therapy for periods extending from one to four months. It is only upon rare occasions that protracted elevation of prothrombin time will be indicated or desired and, until more evidence is available concerning prolonged administration of the drug, an elevated prothrombin time in an individual patient should not be maintained by Dicumarol for periods longer than four to six weeks.

If several successive surgical procedures are planned, special precautions should be taken if Dicumarol therapy is to be used. When subsequent surgical intervention is planned in a patient who gives a history of repeated episodes of intravascular clotting, Dicumarol therapy may be used as a prophylactic measure or for treatment. If Dicumarol is used under such conditions, the subsequent operative procedures should be delayed until the effects of the Dicumarol therapy are no longer apparent —that is, until the prothrombin activity has returned to normal. In the event that an emergency procedure is necessary in a patient who exhibits an increased prothrombin time due to Dicumarol therapy, repeated blood transfusions should be administered until the prothrombin time has returned to, or almost to, normal.

Frequent prothrombin time determinations should be made in the post-operative period and transfusions of fresh blood should be administered as frequently as necessary in order to keep the prothrombin activity at or near the normal for a period of 24 to 36 hours. Subsequent Dicumarol medication may be given but should be carefully controlled by daily determinations of the percentage of prothrombin activity.

When Dicumarol is discontinued, the prothrombin time remains elevated for a number of days. Then it slowly returns to normal, depending on the duration of therapy and to some degree on the total dose of the drug administered. The time required for the return to normal varies from two to ten days, usually about five to six days. It is obvious that the patient should be closely observed during this period.

Undesirable Features

The necessity of carefully controlled Dicumarol therapy has been reiterated because of the danger of hemorrhage from indiscriminate or careless, uncontrolled use of the drug. Hemorrhage is the first and, to date, the only severe untoward reaction which has followed Dicumarol therapy. The possibility of severe hemorrhage due to decreased concentration of prothrombin in the blood, with a corresponding increase in prothrombin time, was brought to the attention of physicians by the extended studies on the effects of decreased prothrombin concentration due to vitamin K deficiency. In Dicumarol therapy the prothrombin concentration of the blood is purposely altered for a therapeutic effect and, unless this procedure is carefully controlled, severe or even fatal hemorrhage might result.

Hemorrhagic tendencies may be manifested by hematuria, by petechiae in the skin, by hemorrhage into or from a wound or ulcerating lesion, or by petechial and purpuric hemorrhages throughout the body. Patients receiving Dicumarol should be examined daily for evidence of these complications and the urine should be tested daily to detect hematuria. When an ulcerative lesion of the gastrointestinal tract is suspected to be present, or when Dicumarol is administered in the post-operative period to patients who have had an operative procedure upon the gastrointestinal tract, the stools should be frequently examined for evidence of hemorrhage into the bowel.

With the reduction of prothrombin activity to between 30% and 40%, there is generally little tendency for hemorrhage to occur. However, if the prothrombin activity is reduced to less than 30%, there is a definite danger. Some patients may show evidence of hemorrhage when the prothrombin activity is only slightly below 30%, while others may show

no evidence of hemorrhage even when the prothrombin activity is less than 15%. Therefore, the dangers of hemorrhage cannot be entirely prognosticated on the basis of prothrombin time determinations and each patient must be closely observed for any signs of a hemorrhagic tendency.

If bleeding develops in a patient receiving Dicumarol, transfusions with fresh whole blood, fresh citrated blood, or fresh plasma should be given freely until the hemorrhage is controlled. Repeated transfusions may be necessary since the effect of a single transfusion may be temporary, lasting but several hours. It has been shown that the prothrombin concentration of stored blood or plasma falls rapidly and, therefore, only fresh whole blood, fresh citrated blood, or fresh plasma should be used in these cases.

Precautionary Use

1. Dicumarol should be administered with great caution in patients who are seriously ill, debilitated, or cachectic.

2. The drug should also be administered with caution in the presence of impaired liver or renal function, since it has been shown that in these states the effect of the drug is markedly enhanced. It should be administered with even greater caution in the presence of jaundice, hepatic cirrhosis, or enlargement of the liver.

3. The drug should be used with caution during menstruation, in menorrhagia or metrorrhagia.

4. Care is required in administering Dicumarol to febrile patients since animal experiments indicate a more intense action of the drug in the presence of fever.

5. In poor nutritional states, as a result of dietary deficiency or failure of absorption of food due to gastrointestinal disease or to certain gastrointestinal operations, the effect of Dicumarol may be accentuated; therefore, it should be given cautiously.

6. Dicumarol should be administered with considerable caution to patients who are receiving large doses of salicylates, such as sodium salicylate, aspirin or similar drugs. The administration of salicylates to patients who are receiving Dicumarol therapy should be inaugurated with caution. Salicylates tend to accentuate the effect of Dicumarol.

7. Dicumarol should be administered with considerable caution to patients who have had brain or spinal operations because of the extreme gravity of the results of hemorrhage if such occurs at the operative site.

Note: In this hospital, it is routine by some doctors to give Dicumarol to all post-operative patients to prevent thrombosis.

A.C.T.H.

Frances Gibson

One of the most important advances in recent medicine has been the comprehension of the role of the adrenal gland in health and disease. As yet only in its beginning, this role now seems to be that of one of the greatest single factors in determining individual health. Many authorities believe that when the details of the true cause and prevention of many of our common diseases are worked out, a new kind of medicine, of teaching, and of treatment may well be evolved. Some even go so far as to say that it may mean the future comprehension of all human illness. To some it would seem, judging by the information we have recently acquired, that individuals whose adrenal glands can adequately react to various types of stresses (trauma, infection, emotion, etc.) may remain well, while

the individual whose adrenal gland hypofunctions or malfunctions or is overstimulated, or whose tissues are insensitive or overactive to adrenal gland stimulation, may come down with one or more of a variety of common diseases.

While these are interesting hypotheses, it will probably be a number of years before the vast extent of this field is fully explored. Although it has been used in various fields of research for several years, it is only recently that A.C.T.H. has been made available for purchase. It is costly and there is still much to learn about it but it has been shown to be a valuable therapeutic agent in controlling a number of serious diseases through the stimulation of the adrenal cortex.

Dr. George Thorn was the first to inject A.C.T.H. in a human being. He determined that the hormone stimulated the adrenal gland. For two years it was used extensively in a variety of research projects, in many human beings, to determine the effect of this stimulation. During this time it was found to be valuable in a number of common diseases. In gouty arthritis, for instance, it was found that a complete remission of all symptoms occurred in a few hours though they often returned in several days following cessation of A.C.T.H. In rheumatoid arthritis the results were striking. In 24 hours after the injection of A.C.T.H., pain completely disappeared, mobility returned, and swelling was gone within three days. In treating nephrotic children, results varied. Some cases went into complete remission, some lost large quantities of accumulated fluid through diuresis after A.C.T.H. was discontinued, and others showed no effect whatsoever. In treating blood dyscrasia, such as leukemia, a short remission of the disease occurred but there was an inevitable relapse.

Perhaps the most promising use of A.C.T.H. is in the treatment of rheumatic fever. Small doses over short periods of time have caused a complete reversal of the clinical disease in most cases and the severe heart disease, that is usually associated with rheumatic fever attacks, has been blocked. Good results have been reported, too, in treating lupus erythematosus, dermatomyositis, acute inflammations of the eye, skin, and intestines. Many types of hypersensitivities have been known to respond to A.C.T.H.

It is yet too early to evaluate A.C.T.H. It is still undergoing intensive study and research at the laboratories where it was discovered and where most of the work on it has been done. It has, certainly, opened up a new field of medicine but it does not make all disease syndromes better. Indeed, some diseases are aggravated by it. Hypertension, for instance, is a condition in which A.C.T.H. is contraindicated. A.C.T.H. causes fluid and electrolyte retention and this aggravates the condition. It is known, though not to what extent, that A.C.T.H. affects carbohydrate metabolism, so it is not given to patients who have diabetes mellitus. In chronic nephritis it is not given because the patient may not be able to eliminate the accumulation of fluid and electrolytes. It is not given to known psychotics because the role of the adrenal gland in mental disease has not, as yet, been made clear. It is never given in Cushing's syndrome because that condition is a result of excessive adrenal cortical function.

When a patient is put on A.C.T.H., a weight chart and an accurate intake and output record should be kept. This is done in order to ascertain whether weight gained is actual weight or whether it is retained fluids. Fluids are moderately restricted with these patients. They are usually put on a high protein diet with a high potassium intake because of the urinary excretion of potassium and nitrogen due to A.C.T.H. stimulation of the adrenal gland. Since the appetite is increased the amount of food given to a patient is increased. Sodium chloride intake is kept at a minimum when the dosage of A.C.T.H. is large in order to minimize the edema. All patients do eliminate the excess fluids and electrolytes when the A.C.T.H. is discontinued.

When a patient is put on A.C.T.H. his temperature should go down to normal within six to eight hours and there should be an early cessation of pain. The general improvement should be marked. If the temperature rises while the patient is on A.C.T.H. or if he develops abdominal pain, the treatment should be stopped because signs and symptoms of acute conditions may be masked while patients are receiving the hormone. There is no specific uniform dose which is effective for all individuals.

Adrenal glands vary, not only in sensitivity, but in sensitivity to A.C.T.H. Doses are usually six hours apart because most clinical evidence has shown that the effects of the hormone wear off in about six hours. The dosage is usually decreased as rapidly as possible in order that the minimal maintenance dose may be determined. When large doses are being given, A.C.T.H. is never stopped suddenly because of the possible effect on the adrenal. A.C.T.H. renders cells immune to many toxic agents. Patients who are highly sensitive to specific drugs, chemicals, or antigens may be given these while on A.C.T.H. without any harmful effect.

Information for this article was obtained from the booklet *A.C.T.H.*, published by The Armour Laboratories, and through observation at Children's Memorial Hospital in Chicago where A.C.T.H. has been used.

The Nursing Care of a Drug Addict

JESSIE MACKAY

DO YOU REALIZE there are 3,000 to 4,000 known drug addicts in Canada today? I was amazed to discover this and even more so when I realized medicine is still therapeutically a pioneer in this field. Informative literature on the nursing care of these people is also very limited and so I am going to relate what I have learned and observed in nursing a drug addict.

First I think you will be interested in some of the patient's case history so that you can better appreciate the nursing problems that faced us. For convenience let us call our patient Mr. Ainsley.

The patient was admitted when I was on day duty as a student nurse. He appeared his stated age of 38 years, was friendly and cooperative in manner, but tense and very talkative. His complaints were "nausea, loss of appetite, nervousness, and shaking." He said he had been a heroin addict for over four years and that three weeks prior to his admission at our hospital he had been in another hospital where he was "suddenly withdrawn." He came to us desiring to be "built up and stabilized."

There are legal factors involved in this case. It began when Mr. Ainsley went to his family doctor complaining of pains in his chest. The doctor considered them to be organic in origin and prescribed heroin for their relief. Within one month Mr. Ainsley became addicted.

He has stated that for the past four years he has been taking 10 grains a day. Permission from the Narcotic Board in Ottawa had been obtained for this medication.

Mr. Ainsley worked rapidly and skilfully at his trade as a die-maker. He was stimulated by the drug but could sleep only two nights a week. His appetite was reduced to one meal each week. If his dose was missed his vision became blurred, he would stagger and become irritable. He tried to

Miss MacKay is a recent graduate of the Royal Victoria Hospital, Montreal.

stop taking heroin but the reactions were too distressing. He was ashamed of his action and kept his drug-taking a secret.

A short time previously the patient had visited another doctor who said he no longer needed heroin for his heart condition and advised Ottawa to remove permission to buy the drug. Three days after our patient's heroin supply ran out he wrote his own prescription, signing a fictitious name, and was "picked up" by the R.C.M.P. Mr. Ainsley was released from court on condition he would enter a hospital to be withdrawn from heroin. When admitted to the Allan Memorial Institute, however, he was still taking the drug.

In regard to the patient's medical background it was found that at the age of 10 years he had had rheumatic fever and at 19 years developed an auricular fibrillation. This condition was thoroughly investigated on admission and found to be serious. He appeared considerably underweight and stated he had lost 60 pounds.

Mr. Ainsley had a well rounded social life. He had married a woman of his own age whom he had known previously for five years. They have six children all under ten years of age. He described his home situation and marital relationship as "wonderful." He is said to be a very popular and much respected citizen of his community with many hobbies and a fondness for music.

On arrival at the hospital Mr. Ainsley was taken to the bathroom, undressed and bathed before being permitted to enter his room. Meanwhile a very thorough search was conducted for concealed drugs in his clothing and other belongings. Mr. Ainsley himself told us later that it is not uncommon to conceal drugs in the most inconspicuous places—for example, in the binding of books. His extra clothing and all valuables, including money, were removed to a place of safekeeping. He was not permitted to have visitors at any time during his stay in hospital nor was he granted any ground privileges. He was immediately placed on special observation until the time of his discharge. This means that at all times his nurses knew where he was and what he was doing.

I have divided the nursing care of Mr. Ainsley into four parts: (a) supportive, (b) protective, (c) treatment, (d) social. First, let me say that the Allan Memorial Institute is an open hospital and does not treat drug addicts often because it has not the facilities to cope with such situations. We are unable to keep the patients from total outside contacts, nor can we refuse to discharge them if they sign a "refusal of treatment" slip.

Supportive Care

This patient was a very glib person of superior intelligence and well informed on all the angles of drug addiction and its treatment. He also had a great deal of medical knowledge about his cardiac condition and did not hesitate to point out to us any little slip we might make in conversing with him. All this made his case more difficult from the nursing point of view.

Because of his addiction we had to assume that he might be unreliable and untruthful—first, because it has been found that drug addicts are loath and afraid to give up the temporary relief the drug gives them. Secondly, this patient did not come voluntarily for treatment. He came under police pressure. It is felt that the drug addict, himself, must express willingness to be withdrawn or the treatment is likely to be unsuccessful. For these two reasons we had to be on the alert for breaks in the withdrawal routine.

Mr. Ainsley was undernourished and had completely lost his appetite. Heroin destroys the appetite and nutrition suffers as a result. To cope with this situation he required close supervision at mealtimes. He was given small attractive servings with additional diet, high caloric milk shakes between meals, and vitamin supplements.

His entire body was covered with scar tissue from the numerous intravenous and hypodermic injections he had given himself. These, he admitted, were frequently given by

unsterile technique. To keep his skin clean and free from abscess he had tepid baths twice a day. During his withdrawal he perspired profusely which increased the danger of skin lesions. Baths also assisted in destroying any drug he might have concealed on his person. Because he was not permitted bedtime sedation, tepid baths helped to control his evening restlessness and promote sleep.

During withdrawal he became most untidy about his room and his person. He required supervision with his toilet and had to be reminded on several occasions to shave and dress. He showed a marked dwindling of his moral and social conscience during this period.

Protective Care

All the psychiatrists I interviewed concerning Mr. Ainsley agreed that he was to be considered potentially suicidal. He made numerous references to "ending it all" but, even in the light of his unreliable trends, his statements concerning suicide were never treated lightly. He displayed periods of depression and elation during which he was carefully observed. It was not uncommon for him to become markedly elated saying, "I have found a solution." At times like these the nursing approach was always one of friendliness and calmness.

To prevent Mr. Ainsley from suicide attempts we routinely removed from him and other patients all scissors, nail files, tweezers, mirrors, knives, razors, matches and lighters. All glasses, dishes, and silverware were carefully counted when leaving the kitchen and on return. Eyeglasses were collected each night and the nurses' office was never left unlocked. All medications were kept in a locked cupboard. At any time, of course, he could have left the hospital against medical advice but he did not do so in spite of his many threats.

Treatment

To briefly summarize his treatment, he was stabilized on methadon as ordered by his doctor, starting with a dosage of 10 grains every four hours which was decreased by one grain each day until he was on sterile water hypos. No other narcotic drugs were given to him because of the possible danger of starting a new addiction and he received no evening sedation. The quantity of sterile water in his hypos was rigidly set at 1½ cc. which could not be varied because the patient was very quick to note any small discrepancy. His doctor ordered this special routine which was rigidly followed and tactfully kept from the patient. This particular point was a difficult nursing problem because of the patient's alertness and suspicion. At this time he required much reassurance.

Social Care

From the nursing point of view Mr. Ainsley was not a very acceptable person during his stay in hospital because he was so untrustworthy and had no control of his mood swings. At times he became very irritable and profane. This was because he was ill and could not help himself. However, in spite of all this, he became very friendly with all the patients and they with him. He socialized freely and during his less restless periods his time was well occupied. He read a great deal and enjoyed music very much, always being interested in listening to the radio, to his records, and to our pianist. He also enjoyed joining into our group sing-songs and watching the other patients dance.

Mr. Ainsley refused to join in strenuous activities because of his cardiac condition but it was not hard to encourage him to play cards and any other quiet games in the day-room. It never ceased to amaze me that all the patients so admired Mr. Ainsley and were so friendly with him. He seemed to attract people to him and, when well, he was considered a popular, respected and active member of his community.

He showed hostility toward us for we were the ones actively responsible for removing his artificial prop. It was most important to be a good lis-

tener to his hostile remarks and to his relation of acquired knowledge regarding our profession. If we once questioned him or untactfully displayed our doubt regarding his statements we would crumble all his confidence in us. Because of his personal pride and dignity he had to be treated with respect and answered at all times by mild, soft-spoken remarks. All hospital staff dealing with him showed that they were not accusing him and made him feel as any other human being who is ill and requires medicine, help, and understanding.

Nursing Care

The nursing care of a patient in withdrawal is difficult. One must be patient, kind, reassuring, friendly and very tactful at all times even if one feels tired and tense after hours of coping with the patient's moods. I recall one occasion when Mr. Ainsley threw his beloved records on the floor and then smashed the pieces. He stormed at the male attendant and became very obstreperous. When he threatened to break the window and casing in his room I sat on the window sill and in a friendly, calm manner listened to him pour out his troubles at great length. I struggled to conceal from him the fear and hostility I felt within me. I don't know why Mr. Ainsley accepted me as he did for I could not have stopped him from doing anything he wished to do but he did not touch me nor did he break the window.

After five days of withdrawal from all narcotic drugs Mr. Ainsley's manner changed. For a time he was depressed and remorseful for what he may have done when being withdrawn but said he could not recall anything that had happened.

Rehabilitation

When dealing with the rehabilitation of these people we must remember that when one has a sense of social approval one can face the world, with the assurance of full support in case of need.

Mr. Ainsley's prognosis remains uncertain. Only 40 per cent of all drug addicts who are satisfactorily withdrawn remain so permanently. It was not possible to give Mr. Ainsley complete psychotherapy as his residence is too far from that city. Unfortunately, there are no psychiatrists in his home area to whom he might be referred. It was impossible for him to remain in the city for further follow-up. His doctor feels this would have been a great help to Mr. Ainsley in dealing with his problems of rehabilitation. At the time of his discharge he appeared to display a motivation toward satisfactory life goals.

A tremendous sense of satisfaction and achievement results from nursing these patients and seeing our combined efforts yield a human being who can once again live and face life without the aid of such escapes from reality as narcotics. We are taught to remember that to understand is to forgive. In this work especially it is the forbearance that she shows in handling her own emotions that spells the difference between a nurse and a good nurse.

New Adhesive Bandage

A new, antiseptic, skin-like adhesive bandage, developed by Bauer and Black, is now available for the first aid treatment of minor cuts, sores and skin infections in homes, clinics, and industry.

The over-all bulk of this dressing is only a minute fraction of an inch. It will conform readily to every movement of the skin, thus avoiding any feeling of discomfort or traction. The covering material is fully waterproof, soil-resistant, and easily cleaned.

Each "Curad" has a small dressing pad containing a blend of tyrothricin, an antibiotic agent, and furacin, an antiseptic.

Though man a thinking being is defined,
Few use the grand prerogative of mind;
How few think justly of the thinking few!
How many never think who think they do!

Lyle Creelman *Writes* . . .

LIFE HAS BEEN hectic but interesting around our Geneva headquarters recently. During the first part of October there were last-minute preparations for the meeting of the Expert Committee on Nursing, which was held the week of October 15. Norena Mackenzie, from the Montreal General Hospital School for Nurses, was a member and was appointed by the group as their *rapporteur*. This means that she had a lot of responsibility in compiling the report on the discussions. In effect, it meant midnight and even later sessions for nearly all the week. Not much time was left to see how we spend our free moments—if any—here in Switzerland.

The chairman was Miss Adranvala of India, with the vice-chairman Miss Petry from Washington. The subject for discussion was "The Preparation of Nurses in Underdeveloped Areas." Don't think that means country X, Y or Z away on the other side of the world! There are "underdeveloped areas" in every country and also "underdeveloped areas" everywhere within the professional field. The interesting discussion touched on how nursing can help to meet the health needs of people and some of the principles involved in the program designed to prepare nursing personnel.

The committee also considered the preparation of nurses going to countries outside their own. The need was stressed for an appreciation of other cultures and for the ability to conform to local custom. This included not only the nurse's personal adaptation but also modifying her particular professional skills. Apropos of this I read in a report recently of a foreign nursing student in a well known university who chose as her subject for seminar discussion "How to cope with international consultants who wish to transport foreign methods wholesale into a country."

You might be interested in how members are selected for an Expert Committee. Each major interest in the health field represented at Headquarters has prepared a list of its specialists all over the world. These form the Advisory Panel for the specialty. When an Expert Committee meeting is to be called which

PART OF THE EXPERT COMMITTEE ON NURSING

Left to right: MISS MURRAY, *Secretary to Nursing Section;* DR. CHISHOLM; MISS TIIRER, *Turkey;* MISS BRIDGES, *I.C.N. Executive Secretary;* MISS MACKENZIE, *Canada.* DR. CARDAU, *Assistant Director General, in background.*

members will be selected from the Advisory Panel will depend on the particular subject or aspect of the subject that is coming up for discussion.

Our panel on nursing includes to date some 30 names, of whom five are Canadians. Panel members serve for a period of five years and are expected to contribute, by correspondence, technical information or reports on developments within their own field when requested by the organization.

Following closely after our meeting on nursing was the first Expert Committee on Maternity Care. It was attended by doctors from India, Indonesia, Chile, England, United States, Belgium and a public health nurse midwife, Miss Brotherus, from Finland. Dr. Eastman, of Johns Hopkins, the chairman, started off in true democratic style by asking each member to review the particular problems in maternity care in their own country. He stated that there seems to be a growing tendency to introduce the assembly-line technique into medicine so that, in spite of highly developed institutions, hospitals, and medical care, insufficient attention is being paid to the patient as a whole and to the personal relationship between doctor, nurse, and patient.

Dr. Pandit, from India, told the group that the first organized efforts to improve maternal care in her country were started by giving some training to the indigenous or native midwife. These women—in India as in many other countries—may be illiterate. Their midwifery knowledge is handed down from mother to daughter. In India the indigenous midwife is called the *dai*, in Indonesia she is the *dukun*, and in the South American countries the term *curiosa* is used. The training which is given may be very elementary, such as the simple techniques of asepsis and recognition of those symptoms for which a trained midwife should be called. Even teaching them not to interfere during the delivery process is important. Dr. Pandit pointed out that in the large cities in India the trend is toward hospital deliveries, this being as high as 80 per cent in some centres. One of the greatest causes of maternal mortality is anemia. In some areas as many as 25 per cent of the maternal deaths are due to this cause. The training for midwifery takes two years but, because of the great shortage of personnel, there are not even enough to fill the hospital positions. Therefore there are few, if any, trained midwives in the domiciliary service.

Chile, reported Dr. Avendano, has a young population and, therefore, a relatively high birth rate. One of the greatest problems is in relation to the nutrition of the pregnant woman. The reason is ignorance rather than poverty. The answer obviously lies in improved health education, which in turn implies more trained health personnel. The trend to hospital deliveries is found in Chile also. Ten years ago only 17 per cent were in hospitals; and now 31 per cent of all babies are born there.

Professor Sarwond Prawirohardjo of Indonesia gave a most interesting account of the problems in his country. Following the war years, there was the struggle for independence. Now one of the big problems to be faced is that of change from the old philosophy of life to a completely new one based on modern ways. The lack of trained personnel to meet the new demands is being faced realistically. For a population of over 70 million they have only about 12,000 doctors, 3,500 nurses, and 1,500 trained midwives. It is realized that the indigenous midwife, or *dukun*, will have to be used for some time, so a plan is being worked out to give these women some simple training. The long-term objective is to replace her with the fully trained midwife. This desire on the part of many countries—where there is insufficient trained personnel and where much reliance has been placed on the untrained worker—to prepare better qualified health personnel is one of the most encouraging factors in our international work.

EXPERT COMMITTEE ON MATERNITY CARE
Left to right: MISS BROTHERUS, *Finland;* (*Finance Officer of WHO*); DR. PANDIT, *India;* DR. SCHMIDT, *U.S.A.;* DR. PRAWIROHARJO, *Indonesia.*

Miss Brotherus of Finland reported that the amazingly high figure of 94 per cent of all mothers in that country receive prenatal care. The law requires that there must be one midwife for every 5,000 people. If there are more than that number in the district then two midwives must be employed. In reality it works out to one midwife for little over every 2,500 of population. The midwife is responsible to the doctor. Working in the same district, and frequently sharing the same house, is the public health nurse, who is responsible for all the public health program excepting that in relation to the pregnant mother, the delivery and the care of the infant for the first 14 days. Finland is working on the assumption that every mother who wishes to be delivered in hospital should have that service. At the present time more than 55 per cent of them go to hospital.

An interesting development in Finland is the provision of "home help service" for every mother who requires it during her confinement, whether in hospital or in the home. These workers are trained to take the place of the mother in the home, even carrying out the many duties on the farm such as feeding the chickens and milking the cows. Conditions in Finland are similar to those in our prairie provinces and northern areas—severe winter climate, lack of transportation, and sparsely settled areas with hospital facilities far distant. Added to this the particular problem of the public health nurse in Finland is that she does not have motor transport. She travels by bicycle or horseback in summer and on skis in the winter.

Belgium, said Dr. Snoeck, owes many of its problems in maternal health to industrialization. For example, premature rates appear to be higher where the mothers are working in industry and, particularly, where they continue to work late in pregnancy.

The United Kingdom maternity services, including care given by the doctor or midwife, or both, and hospitalization if desired, are free. Dr. Nixon reported that now 50 per cent of deliveries are in hospital. Formerly nearly all normal deliveries, both hospital and domiciliary, were attended by the midwife. There has been a trend recently for more deliveries to be conducted by the doctor.

These have been only a few of the highlights of the discussion which took place on the first day of the meeting. As I write, it occurs to me that the United States and Canada seem to be the only countries in the world where, but for a few exceptions, the practice of midwifery is not legally recognized. It was sometimes hard for those of us from these countries to realize that this important aspect of nursing is, in most of the world, shared with another worker. Perhaps we need to give some thought to encouraging more of our North

American nurses to study midwifery. Certainly in every one of our WHO nursing projects the midwifery program must be planned concurrently with nursing, through formal instruction, provision of field experience, and on-the-job training of those already in practice. One of our greatest recruitment needs is for midwifery instructors and for public health nurse midwives who have had experience in domiciliary midwifery and who can teach and supervise both the trained and the untrained midwife.

In the Good Old Days

(*The Canadian Nurse*, JANUARY 1912)

"The superintendent of schools has introduced a system of breathing exercises which has produced in some cases an expansion of six and even seven inches and the general average of lung expansion has been greatly increased. Doubtless this will render the youngsters less susceptible to the inroads of the dread disease—*tuberculosis*."

* * *

"Dr. Rucker, health officer, has struck the keynote in his organization of 'health bands' among the children for the cleaning of back yards and alleys. This campaign will be an excellent education for the children and, if followed up, it will have an educative effect upon the older folks. . . . One citizen confessed to the doctor that he was never more ashamed in his life than when a member of this band knocked at his door and informed him respectfully that his garbage barrel needed a new cover. The cover was promptly obtained and installed."

* * *

"In the home treatment of scarlet fever I have used eucalyptus oil for 25 years. For the first four days I have rubbed it *all over* the body from the crown of the head to the soles of the feet twice a day, then once a day until the tenth day of the disease. The aroma fills the room. It greatly modifies the throat and kidney trouble. Ear and nose complications I have not known. The tonsils, however, I always swab with one in ten carbolic oil every two hours the first day. This greatly relieves the pain and enables the patient to swallow. On many occasions I have kept a child in a ward with from six to 20 others without any infection spreading."

* * *

"A new scale of fees for private duty nurses became effective in Montreal on January 1, 1912. The general fee is now $3.00 a day and for infectious cases $4.00 per day."

* * *

"The Anti-Tuberculosis Society of Prince Edward Island has engaged Miss Emmeline Stuart, a graduate nurse, to visit country districts and give instructive talks in the different school-houses on 'The Prevention of Disease.'"

Nursing Sisters' Association

The *Ottawa Unit* held their annual Remembrance Day dinner when seated at the head table were: President, E. Pepper; Mayor Charlotte Whitton, guest speaker; E. Smellie, A. Macleod, D. Percy, M. Kemp, G. Scott, E. Bagnall, E. Schryer, Mmes J. Stitt and H. D. Coghill. Mayor Whitton was introduced by Miss Macleod and thanked by Miss Percy. The latter also addressed the group, telling of the work done during the past months in A.B.C. warfare.

Sarah Miles, R.R.C., president, represented the *Saint John Unit* at the civio reception given for Princess Elizabeth and the Duke of Edinburgh.

The Unit met for luncheon and later attended in a body the Remembrance Day service at the Cenotaph. The salute for the marchpast was taken for the first time in Saint John by a woman—Nursing Sister Mary Edgecombe. N/S Edgecombe laid a wreath at the Cenotaph.

Institutional Nursing

Preparation for Living

HELEN RUSHTON

IT WAS A sharp cold morning in January. An all-night snow was still falling heavily. In his down-town headquarters office, a Vancouver police announcer sat before a microphone, broadcasting overnight reports. He was handed a bulletin: "A teen-age skier reported missing on nearby Mount Seymour."

In newspaper offices and radio station newsrooms, reporters and announcers went into action. Early editions carried reports of the skier's disappearance and radios announced that ski rescue patrols were on the way. Anxious citizens from Vancouver and nearby municipalities, members of the mountain ski patrols, left their offices and homes to join in the search for the missing skier. Among the volunteer searchers were two student nurses from the Vancouver General Hospital.

After hours of searching, the skier was found, exhausted and suffering from long exposure. The student nurses assisted in giving first aid to him. Beyond the call of duty, they had performed a valuable community service by putting their training to practical use.

It was not by accident that student nurses from the Vancouver General Hospital were members of the ski rescue patrol. Extra-curricular activities, including skiing and other sports, are encouraged as part of the social program of the hospital's school of nursing. The doctors and teaching staff believe that these activities mean a better student and a better graduate nurse.

In nursing, as in most professions, there is the tendency to become limited to one's own particular field. A good nurse develops skills in the care of patients but she owes it to herself, her patients, her co-workers, and to the community in which she practises her profession to develop the social and cultural sides of her personality.

Student nurses at the Vancouver General Hospital have ample opportunity to round out their education with indoor and outdoor activities during off-duty hours. During the first four months of their training, they are required to spend nine hours a week in exercise. Nor does this mean only gymnasium work and calisthenics. These hours can be used for skiing, riding, golfing, hiking, swimming, tennis, badminton, and other sports.

Some years ago, Vancouver General Hospital authorities decided that a well balanced social program was necessary if student nurses were to

Eric Cable Photo

Nurses are skiers

Mrs. Rushton is social director in the nurses' residence at the Vancouver General Hospital.

step out into the community as mature, personable young women with a normal complement of outside interests.

The social director for student nurses is a nurse who does not wear a uniform. In a liaison capacity between the director of nursing and the students, she serves as a personal counsellor when necessary and plans the students' extra-curricular program in close cooperation with the staff. She assists the students in arranging cultural and recreational activities, both in residence and in the community.

For students with musical tastes, season tickets for Vancouver Symphony Orchestra concerts and feature entertainment attractions are available without charge to the students. There are also weekly Glee Club sessions for members of the preliminary class and other students. Singing lessons are arranged, too, for the students.

A well stocked library is an important part of the new residence. The library, open to all students, is being built up on approved library principles, with a part-time librarian in charge. The Women's Auxiliary to the Vancouver General Hospital provided $1,000 for the purchase of books for the library.

Self-government is an important phase of the student nurses' extra-curricular activities. The Students' Council is elected annually by the students themselves, with the director of the school, the social director, and the residence supervisors serving in an advisory capacity. The council represents all students in the school excepting the preliminary students.

Each autumn, a carnival is presented by the council to raise money for some special project. In the past, proceeds have been used to send food parcels to children in Britain and Greece, warm capes for nurses in Holland, as well as for social and cultural activities. Part of the proceeds is used each year to provide a scholarship for post-graduate study for a graduate nurse.

Tennis is enjoyed by students on public courts near the hospital. A keenly-contested tennis tournament is held each August between the students of Vancouver General Hospital and St. Paul's.

Softball is played regularly on the Vancouver Normal School grounds, one block from the hospital. Many of the students spend their off-duty hours during the summer months at beaches and at parks located near the hospital. Vancouver, often called the vacationland of Canada, offers ample facilities for all outdoor activities.

For three months during the year, students have access to a summer camp at Crescent Beach, less than an hour's drive from Vancouver. Last summer more than 600 students visited the camp, several of them for all or part of their four-week vacation. For six months, lodging is reserved for them in a supervised ski cabin on Grouse Mountain, a popular winter playground.

Basketball games and special dancing classes are made available through the Pro-Rec program, a joint recreational program of the Vancouver School Board and the Provincial Department of Education. Badminton and swimming are arranged for the student nurses at the Canadian Memorial Church gymnasium and swimming pool. Many of the students also attend the Provincial Recreational Centre at the nearby Normal School, where a varied program of rhythmic exercises and folk dancing is presented.

Facilities are arranged by the Students' Council, director of nursing, and the Board of Trustees. Funds for these extra-curricular activities are provided both by the hospital and by the students themselves.

A member of the hospital's Board of Trustees said recently:

> Nurses, of necessity, are conversant with the dynamic developments of medical science but they are close to the basic thoughts of human beings. Because of this combination of knowledge, student nurses upon graduation are well equipped to take a full part in the cultural, social, and scientific life of the community in which they choose to practise their profession. They can use their knowledge to keep the balance between human values and scientific progress.

Certainly, a nurse in training at the Vancouver General Hospital has every opportunity to develop every facet of her personality—the best assurance of a full and happy life in the community in which she chooses to practise her profession.

In Memoriam

Phyllis Mary Appleton, who graduated from the Winnipeg General Hospital, died in Winnipeg on October 10, 1951, at the age of 50.

* * *

Norma Violet Beckstead of North Bay, Ont., who graduated last spring, died on October 6, 1951, following an attack of poliomyelitis. She was just 21.

* * *

Martha A. (Sneath) Bell, who graduated from the Toronto General Hospital with the class of 1894, died in Toronto on October 23, 1951, after a prolonged illness.

* * *

Harriet Johanna Coleman, one of the first graduates of the Hamilton General Hospital died in Hamilton, Ont., on November 12, 1951. Always a faithful worker, Miss Coleman had been active until last year.

* * *

Jennie Myrtle Dunbar, who graduated from Chipman Memorial Hospital, St. Stephen, N.B., in 1923, died on October 30, 1951, at the age of 52. Miss Dunbar engaged in private nursing following graduation, later becoming night supervisor at the hospital. She was appointed Red Cross district nurse for the St. Stephen area in 1940. She gave of herself unstintingly until she became ill last April. Always keenly interested in professional activity, Miss Dunbar had served as a member of the executive board of the N.B.A.R.N. and as president of the St. Stephen Chapter.

* * *

Bessie Craig Elliott, who graduated from St. Luke's Hospital, Chicago, in 1909, died in Toronto on October 7, 1951. Miss Elliott was engaged as a school nurse by the Toronto Board of Education in 1912. When the school health service was taken over by the Department of Public Health in 1917, she continued her activities. She retired in 1945.

* * *

Betty Jean Hooke, who graduated from the Women's College Hospital, Toronto, in 1941, died in Toronto on October 4, 1951, after being ill for two months. A brief period of service on the staff of Wellesley Hospital, Toronto, preceded Miss Hooke's enlistment in the nursing service of the R.C.A.F. She was stationed at Rockliffe, St. Thomas, and Trenton. Following the close of World War II she returned to Wellesley Hospital.

* * *

Isobel K. McIntosh, who graduated from Buffalo General Hospital in 1916, died in Brantford, Ont., on October 6, 1951. After engaging in private nursing for a time she became a supervisor at Wellesley Hospital, Toronto. She joined the foreign missionary service of the United Church of Canada and was sent to China in 1919, serving four terms in various provinces. In 1948 she returned to Canada and served for one year at Mission Hospital, Vita, Man.

* * *

Margaret McMillan, who graduated from the Toronto General Hospital in 1897, died in Ayr, Ont., on November 11, 1951. Miss McMillan had worked in Toronto, New York, and Tacoma, Wash., before retiring some years ago.

* * *

Jean Russell, a graduate of the Brockville General Hospital, Ont., died in Toronto on November 13, 1951. Much of Miss Russell's nursing career was spent in Western Ontario.

* * *

Myrtle (Campbell) Shea, who graduated from St. Michael's Hospital, Toronto, in 1919, died there on July 6, 1951, after a prolonged illness.

* * *

Joy (Henery) Young, who graduated from St. Michael's Hospital, Toronto, in 1942, died following a Caesarean operation in Dauphin, Man., on July 9, 1951. Mrs. Young had worked on the staff of the Dauphin General Hospital and of St. Peter's Hospital, Melville, Sask., prior to her marriage.

Public Health Nursing

Preparation of the Public Health Nurse

LOIS SMITH

THE BAILLIE-CREELMAN Report on public health practice in Canada shows very clearly the lack of qualified public health nurses. This brings up the question: What is meant by a qualified public health nurse? Such a person has need of professional competence in technical nursing, interpersonal relationships, leadership, planning and problem solving. This covers a wide field and indicates the need for great versatility since the public health nurse is a teacher, counsellor, and leader.

In Canada there are two methods of preparation for public health nursing: (1) the basic nursing course plus one or two years of public health nursing at a university; (2) the five-year degree course, which includes public health practices and principles integrated throughout the basic course. By far the greater number are prepared by the first method.

The Report states: "There is a great variety of public health nursing practice across Canada today." This ranges from bedside nursing, infant and maternal hygiene, mental health, school health service, tuberculosis, communicable disease control to midwifery and minor surgery in some areas. A vital part of all these services is health teaching. Then, too, the public health nurse must take her place in the community. She is called upon to participate and give leadership in many community projects.

In order to carry out such a program efficiently and effectively, the nurse must have a sound preparation in all basic nursing skills—the social and health aspects of nursing, principles of learning and teaching, techniques of interviewing, counselling and guidance, public speaking, group dynamics. Added to these, a thorough understanding of normal growth and development is essential. A study of the courses given across Canada shows a lack of standardization both in length and content, yet graduates of these schools are expected to work in all these varied fields. Facilities for field practice are often inadequate to provide the necessary experience.

The first step in standardizing the preparation of the public health nurse would be to follow the recommendations of the Report that:

> This matter is referred to the Education Committee of the Canadian Nurses' Association and the Council of University Schools and Departments of Nursing with the recommendation that a study be made of the method of preparing nurses so that they may be more fully qualified to contribute to the community's health services.

Since most nurses are prepared by the addition of one year of post-graduate work at a university, following the basic course, it would be wise to include more positive health teaching in the basic course. The student nurse should also be given an opportunity to both observe and participate in community health programs. This is not always possible due to lack of adequate staff and well organized practice fields.

Since field experience forms a very important part of the preparation of the public health nurse, this phase of the program should be given special

Miss Smith is supervisor of mental health nursing with the Public Health Nursing Service in the province of New Brunswick.

consideration. Agencies accepting students, either for observation or practice work, should provide: adequate supervision, which means one supervisor to every eight staff nurses, and satisfactory personnel policies. A well planned educational program is desirable for students as well as for personnel already employed. Provision for professional training of staff by refresher or post-graduate courses and attendance at meetings is essential.

The Report speaks of nursing in child health services and the study has shown a great weakness here. Many nurses feel ill prepared in this field. The greatest weakness appears to be the lack of adequate preparation in child development. The nurse should be well grounded in the variations of normal growth in order to discuss this phase of the work intelligently. Mothers bring their children to the child health centres seeking guidance and expect the nurse to know whether or not her child is progressing normally. The background of the nurse should be such that she does not consider children as a group developmentally, classified according to age, but will recognize that each child is an individual with its own individual rate of development both physically and psychologically. By means of discussion and teaching, the mother will see each of her children as an individual, each with its own rate of progress.

In order that the nurse may meet this need on the part of the parents, the public health nursing course should include a much more comprehensive study of child development than that generally given. The agency employing the nurse must realize that it, too, has a responsibility and should provide for continuous staff education in this, as well as other subjects. The Department of National Health and Welfare provides excellent literature, suitable for both nurse and parent. Provincial and civic health departments also have valuable educational pamphlets and books. All of these should be made available, in order that the nurse may become familiar with the content and make use of such information in her daily work. From such material, conference guides may be prepared for use in the child health centres. Such a guide will not only increase the knowledge of the nurse but will be invaluable in discussions with parents. A staff education program that keeps abreast of the times will keep the nurse informed on newer trends in child guidance.

Added to this most essential preparation in child development, the nurse must have good knowledge of mental health. Mental health is not a separate entity in itself—something remote from the person—but is included in the word "health," as defined by the World Health Organization: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."

It is essential that the nurse understand this in order to carry on a good health program in the community. To successfully carry on good health teaching, not only in the child health program but in all other phases of the work, she must be able to understand that the word "health" includes the whole person. Such understanding is essential in order to establish good relationships in the work situation—that is, with those concerned with the work at hand, either directly or indirectly, and with the general public. With the inclusion of mental health subjects as a *must* in the public health nursing course, the nurse will have a better understanding of basic human nature both in herself and in others. She will be better able to assess the relationships she builds up with the individuals she deals with and determine how that individual is reacting to her. The relationships built up and maintained between the nurse and her public will determine just how effective her health teaching will be.

From all this it can be seen that the preparation of the public health nurse is a continuous educational process. It starts when the student first enters a school of nursing, continues through her course in public health nursing, and then through an in-service educational program by the

employing agency. The pre-employment preparation of a public health nurse should include, first of all, the basic nursing skills and sciences plus courses in: principles and practices of public health nursing; sanitation; the social sciences which include case study methods, principles and practices of teaching, techniques of interviewing, counselling and guidance, public speaking, group discussions and dynamics; psychiatry; psychology; child development; and added to this at least three months of well planned field experience. With this background of preparation, the public health nurse should first seek employment in a well organized agency which provides adequate supervision and a well planned educational program. Such experience would provide opportunity for professional growth and thus prepare the nurse for independent work.

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Duties of Probationers

The regulations that were set down for would-be entrants to the Nightingale School at St. Thomas's Hospital, London, in 1859, required that all probationers must be "Sober, honest, truthful, trustworthy, punctual, quiet, orderly, cleanly and neat."

The various nursing techniques in which the probationers were expected to acquire competence were set down as follows:

"*You are expected to become skilful—*

1. In the dressing of blisters, burns, sores, wounds, and in applying fomentations, poultices and minor dressings.
2. In the application of leeches, externally and internally.
3. In the administration of enemas for men and women.
4. In the management of trusses, and applications in uterine complaints.
5. In the best method of friction to the body and extremities.
6. In the management of helpless patients —i.e., moving, changing, personal cleanliness of feeding, keeping warm (or cool), preventing and dressing bedsores, managing position of.
7. In bandaging, making bandages, and rollers, lining of splints, etc.
8. In making the beds of the patients, and removal of sheets whilst patient is in bed.
9. You are required to attend at operations.
10. To be competent to cook gruel, arrowroot, egg flip, puddings, drinks, for the sick.
11. To understand ventilation, or keeping the ward fresh by night as well as by day; you are to be careful that great cleanliness is observed in all the utensils: those used for the secretions as well as those required for cooking.
12. To make strict observations of the sick in the following particulars: The state of secretions, expectoration, pulse, skin, appetite; intelligence, as delirium or stupor; breathing, sleep, state of wounds, eruptions, formation of matter, effect of diet or of stimulants, and of medicines.
13. And to learn the management of convalescents.

The term of a probationer's service was a complete year. They were admitted to training on the distinct understanding that they would remain for that length of time. However, they were subject to discharge at any time by the matron, in case of misconduct, inefficiency, or neglect of their duties. They were eligible for permanent appointment as nurses at the end of their year.

Aux Infirmières Canadiennes-Françaises

Stage à un Hôpital Régional

HÉLÈNE LAROSE

LE 4 DÉCEMBRE 1950, l'Hôtel-Dieu de Saint-Jérôme ouvrait officiellement ses portes. Et déjà, la veille au soir, cinq malades y faisaient leur admission. Des cinq étages, trois étaient ouverts aux patients, soient 150 lits y compris la pédiatrie.

Cet hôpital général, ayant une capacité de 250 lits, est sous la direction des Religieuses Hospitalières de St-Joseph dont le généralat est à Montréal. Construit aux abords de la ville, l'Hôtel-Dieu est entouré d'un bois magnifique qu'on a dû reculer pour bâtir. Il est parallèle à la route, de sorte qu'il sera facile d'y ajouter de nouvelles ailes lorsque l'exiguité l'exigera. Dès l'entrée, les lignes modernes et harmonieuses frappent l'oeil. On se sent immédiatement chez-soi, surtout pour une élève de l'Hôtel-Dieu de Montréal.

Le chauffage central et l'éclairage au néon sont des plus nouveaux. De plus, chaque chambre est munie d'un Sonata par lequel la garde-malade au poste peut répondre à ses patients sans se déranger. Chaque étage possède une chambre d'utilité et de pansement pourvus de tout, en vue des thérapeutiques les plus diverses.

Note: Le Comité des Ecoles, à titre d'expérience, a autorisé un certain nombre d'élèves à faire un stage d'un mois le dernier de leur cours, à l'Hôtel-Dieu de St-Jérôme. Une visite officielle avait été faite à l'hôpital et un plan préparé pour le stage. Un rapport devait être préparé par chacune des élèves. Une seule élève, à date, a bénéficié de cette expérience. Sans retouche, sans commentaire, nous vous présentons le rapport qu'elle fait de son stage dans un hôpital régionnal.—SUZANNE GIROUX

Les services de chirurgie, d'oto-rhino, et d'orthopédie n'ont qu'un chef respectif. Cependant, au point de vue médecine, pédiatrie, obstétrique, l'hôpital est considéré ouvert puisque tous les médecins peuvent y traités leurs patients. Environ 40 de cette catégorie du Bureau Médical y sont attachés. L'hôpital compte dans son service général 20 graduées de différentes écoles de la province animées de véritable collaboration et d'une grande sympathie. Vingt aides, n'ayant aucune préparation spéciale, font le travail routinier: toilette, lits, ménage de la chambre, etc. Quatre infirmiers dont deux de jour nous secondent à l'étage des hommes.

C'est précisément à ce département que j'ai fait mon stage. Chirurgie (ortho., oto-rhino.), médecine—tout s'y rencontre. Les cas A. P. aussi bien que les cas payants sont admis. Car, il est stipulé dans le Code Médical qu'un "médecin ne refusera pas de donner ses soins à un indigent hospitalisé," à plus forte raison, l'Hôtel-Dieu est-il porté envers les pauvres.

La garde-malade a un service de 10 patients aidée d'un infirmier par 20 lits. Chaque heure est bien remplie, les traitements étant assez nombreux. Les malades se soumettent facilement à tout cela, si on veut bien leur en expliquer l'importance. On reste parfois surpris de constater que des gens très humbles soient au courant de certains progrès médicaux, de certaines thérapeutiques. La médecine est tellement vulgarisée maintenant que même les plus ignorants en savent quelque chose. Non! La mentalité des campagnes ne diffère pas tellement de celle des villes et c'est avec un véritable enthousiasme que l'on

a accueilli le nouvel hôpital. Pas un des patients à qui j'ai posé la question: "Trouvez-vous que c'est une amélioration?" ne m'a répondu négativement. On reconnaît que:

1. Les mères ont moins de soucis en accouchant à l'hôpital.
2. Les blessés, si nombreux aux carrefours du nord, sont plus vite secourus.
3. Les parents ont moins loin pour visiter les malades que s'ils étaient hospitalisés à Montréal.

Et quelle confiance les malades ne mettent-ils pas dans leur médecin — médecin de famille pour beaucoup — et dans la garde-malade qu'ils considèrent énormément! Les statistiques des sept premiers mois révèlent 2,370 hospitalisés soit un total de 19,961 jours. C'est là une preuve d'estime de la part de la population, de compréhension également.

L'hospitalière-en-chef voit à l'admission et au départ des patients. L'officière est maîtresse de son département. Il n'existe pas de sous-officière; chaque garde-malade se considérant responsable en l'absence de la religieuse. Cette responsabilité est compensée par le système de centralisation: cuisine, stérilisation, lingerie, laboratoire de lait, etc. C'est autant de minutes épargnées sur le département pour donner davantage dans le service. Le travail est intéressant autant que divers. La préparation des menus, donnant à chacun sa diète appropriée, la rédaction des dossiers, et les comptes à enregistrer sans omettre le contrôle des narcotiques prennent bien quelques heures de la journée. En effet, c'est à chacune de nous à enregistrer les narcotiques prescrits. A son tour la pharmacienne vérifie pour que tout soit exact à la visite du contrôleur officiel.

Soeur Perreault, responsable de l'obstétrique et de la maternité, cumule également la charge de s'occuper des graduées. L'hôpital paye selon l'échelle des salaires établie — soit $145 pour le service général; plus une augmentation de $10 durant trois ans. En service de nuit, la rémunération est portée à $10 de plus, avec les mêmes avantages, De plus, l'hôpital fournit chambre et pension moyennant $25. C'est un grand avantage pour l'infirmière qui n'a pas à se préoccuper de cette question et d'être si près de son travail.

En somme, pour un hôpital récent, l'organisation est relativement excellente, et cela pour deux raisons:

1. Parce que le travail est simplifié par le "tout moderne."
2. Parce que chaque membre des différents personnels collabore franchement à un même but, dans une atmosphère de sympathie.

Grâce à l'intermédiaire de Soeur Perreault, j'ai pu étudier un peu le fonctionnement de l'Unité Sanitaire du comté. Depuis 25 ans et plus, cette unité est établie, englobant un territoire de 39 paroisses, un des plus vastes de la province. C'est dire que l'officier médical et ses six gardes-malades ont une somme énorme de travail à fournir. La gentillesse du Dr. Leclerc m'a permis de me rendre à une clinique des environs. Par le nombre de mamans qui s'y rendent avec leurs enfants on peut présumer que les gens comprennent assez bien l'importance de l'immunisation et des consultations.

Réunis dans une même injection, le vaccin pour la diphtérie, la coqueluche, et le tétanos se donne à la dose de 1 cc., trois mois consécutifs. Un an plus tard, c'est le "rappel" et à l'âge scolaire l'enfant doit se présenter à nouveau pour une dernière dose. Et généralement, nous dit l'infirmière, les mamans sont assez fidèles à nous les ramener.

Le B.C.G. par scarification est administré à tous les nouveaux-nés dont les parents acceptent la vaccination. A la voie buccale d'autrefois, on a substitué ce dernier mode qui s'avère plus efficace. Malheureusement, il se trouve encore des gens qui comprennent mal cette prévention. Ainsi, Mme X qui amène sont bébé à la clinique. Il présente des ganglions sous-axillaires, apparus le jour même de l'injection du B.C.G. La mère conclut — et n'en veut pas démordre — que ces "bosses" sont dues au vaccin et que jamais plus ses enfants ne reviendront. Malheureuse coincidence qui détourne les parents ignorants du bien que peut procurer l'Unité Sanitaire. Des cas semblables sont devenus presque des exceptions dans la comté de Terrebonne, grâce au dévouement incessant du médecin et de ses dévoués infirmières.

Le Dr. Leclerc même depuis quelques années une guerre ouverte à la tuberculose, par la prophylaxie et le dépistage des cas. Son initiative et sa ténacité lui ont valu trois appareils à radio pulmonaire. Ces appareils, placés aux trois plus gros centres du comté (St-Jérôme, Ste-Agathe et Ste-Thérèse), fonctionnent en permanence. Sans rémission, un patient découvert T.B. est envoyé dans un sanatorium. Car l'on sait bien qu'il faut enrayer le mal à la racine et que cette racine nait des expectorations du malade. Cette visite à la clinique de Ste-Thérèse m'a fortement intéressée. Tantôt avec le médecin tantôt avec la garde-malade, j'ai pu étudier "grosso-modo" comment fonctionnent ces cliniques d'immunisation et quelle collaboration d'esprit les parents y apportent.

Le lendemain, j'allais à domicile avec Garde Huot, i.h., faire quelques visites chez les prénatales. Les mamans causent tout bonnement avec l'infirmière qui s'enquiert du régime, des exercises, de l'état de santé de la future mère. On sent leur confiance en celle qui les dirige un peu, qui leur distribue des conseils appropriés surtout dans la classe moins aisée. Cette visite de la garde-malade m'a paru être un récomfort pour la mère qui s'inquiète parfois à tort de son état et des circonstances dans lesquelles se déroulera l'accouchement.

Je calcule que ce mois fut pour moi une véritable richesse m'ayant révélé des horizons inconnus et placée dans un cadre hospitalier différent de celui de nos grands centres.

A New Twist to Recruitment

The continuing demand for nurses has stimulated many active campaigns to interest high school girls in entering our profession. Last autumn Sister Mooney, who is instructor of nurses at Hotel Dieu Hospital, Cornwall, Ont., launched a slightly different approach to this program which is worthwhile sharing with other schools of nursing. After consultation with the vocational director at the local Collegiate and Vocational School, a series of projects was evolved which, it is hoped, will stimulate, heighten, and intensify the interest of girls in Grades X and XI in nursing as a career. The program is planned to extend over the two-year period before these girls complete high school.

The first project took the form of an observational tour last November. A group, comprising 48 students, three teachers, and the vocational director, gathered in the spacious classroom of the school of nursing where Sister Mooney explained in simple terms just what it means to be a nurse, what subjects to stress in high school, and how to prepare both educationally and culturally for nursing. Plans were made for a joint meeting of this group with the faculty and students at the school of nursing in February, 1952.

The visitors were then divided into four groups. Escorted by a Sister, each group enjoyed a planned tour through the hospital from the operating suite to the laundry. The students were amazed at the size, capacity, and daily output of clean linens from the laundry. Some of them wondered how it was possible to keep the whole institution so clean with so much traffic and with the wards overcrowded!

One of the students said, "I was so busy looking at all the interesting things in all of the different departments I forgot to watch the nurses. Could I come back some other time and just watch them?" This remark was typical of the enthusiasm that this first step in the program has evoked. Pictures on the bulletin board in the classroom, depicting scenes from the life of the student nurse, as well as the many opportunities open to graduates, proved very intriguing.

Subsequent features of the program include the showing of films on various aspects of nursing and the distribution of suitable literature. It is planned that the high school girls will be given the opportunity of coming to the school of nursing in small groups to sit in on some of the nursing lectures.

Nursing Profiles

Anna Judson Rosborough Mair recently celebrated her Silver Anniversary as superintendent of the Prince Edward Island Hospital in Charlottetown. At the annual meeting of the alumnae association the occasion was commemorated by the presentation to Miss Mair of a beautiful silver tray.

Born in Moose Head, N.S., Miss Mair moved to P.E.I. when a child, receiving her schooling there. She graduated from the Prince Edward Island Hospital and joined the staff there as operating room supervisor. Her administrative ability was soon recognized and she was appointed to her present position in 1926.

An active supporter of professional activities, Miss Mair has been secretary and president of the provincial nurses' association. She has a life membership in the Wohelo Club of Charlottetown. She has travelled widely in Europe and throughout various parts of the Western Hemisphere. Her many friends join in wishing her many more years of happy leadership in her chosen field.

Florence Juliana Breau is the superintendent of nurses and principal of the school of nursing of the Moncton Hospital whence she graduated in 1928. Born in Moncton of French parentage, Miss Breau engaged in private nursing for two years following graduation. She joined the permanent staff of the hospital in 1930 and moved up through various positions to become assistant superintendent of nurses in 1947. Her appointment to her present responsibilities was confirmed last year. Miss Breau finds relaxation through her interest in handicrafts. She can even make most of her own clothes!

FLORENCE J. BREAU

Kathleen Marshall was born and educated in Leeds, England. She turned to psychiatric nursing as her chosen work and received her training in this field at the Ontario Hospital in London, Ont. General staff work there was followed by a six-month postgraduate course at the Toronto Psychiatric Hospital. Miss Marshall returned to London as a supervisor. In 1943 she received her certificate in teaching from the University of Toronto and subsequently served as instructor at London for two years before joining the teaching staff of the Allan Memorial Institute, Montreal. Since 1948 she has been in charge of the nursing service in the Institute. She has been associated with the McGill School for Graduate Nurses since 1945, when she became a part-time lecturer in psychiatric nursing. As the special postgraduate course for supervisors in this field expanded, Miss Marshall has assumed a larger part of the responsibility for these students.

Notman, Montreal

KATHLEEN MARSHALL

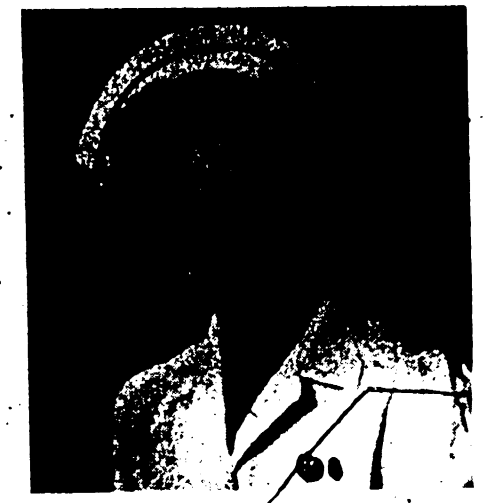
She is chairman of the Committee on Psychiatric Nursing of the A.N.P.Q. A member of the Canadian Girl Guide Association and of the Soroptimist Club of Montreal, she is an industrious knitter, enjoys reading and walking.

Evelyn May Robson is director of nursing and principal of the school of nursing of the Peterborough Civic Hospital, Ont. Graduated in 1929 from the Toronto General Hospital, Miss Robson secured her B.S. degree from Teachers College, Columbia University, majoring in administration and guidance in basic schools of nursing.

Beginning as a head nurse immediately following graduation, Miss Robson moved up gradually to supervisory positions at T.G.H. To round out her hospital experience she transferred to the teaching department, serving as educational director for two years. In 1946 she became assistant superintendent of nurses at the St. Catharines General Hospital. More recently she had a brief period of experience as inspector of training schools under the Ontario Department of Health. Her leisure-time pursuits include reading, the theatre, bridge, and motoring. She is a member of the Business and Professional Women's Club.

Peterborough Examiner

EVELYN M. ROBSON



Imperial Studio, Hamilton

M. AMY WHITE

M. Amy White is superintendent of the General and Marine Hospital in Collingwood, Ont. A year as head nurse at Toronto General Hospital followed her graduation from that institution. Private nursing lured her from staff ranks until her enlistment with the nursing service of the R.C.N. in 1941. Miss White was slated for duty at Greenock, Scotland, where she became assistant matron of *H.M.C.S. Niobe*. She was also attached to *H.M.C.S. Stadacona* at Halifax and *H.M.C.S. Cornwallis*. Following her discharge in 1945, Miss White became the night supervisor at the Hamilton General Hospital. Though she finds that there is precious little time left for leisure in her new work, she enjoys reading and golf whenever possible.

The pessimist and the optimist were once discussing the world. The pessimist brought the discussion to an end (as he thought) with a clinching argument. Said he, "Well, I believe I could have made a better world than this myself." "True," said the optimist, "that is what we are here for. Now let's get busy and do it!"

Trends in Nursing

Biennial Meeting

THE 1952 BIENNIAL MEETING will be held in the Chateau Frontenac, Quebec City, from Monday, June 2 to Friday, June 6, inclusive. Why talk about June in the middle of January? Well, time has a way of slipping along very rapidly and planning is needed to arrange for leave of absence and to budget expenses. If you are a recent graduate, you will want to attend this meeting to learn what your association does, what you can expect from the C.N.A., and what you can do to help your organization build for the future. If you are an experienced nurse, you are needed to help shape nursing policies.

All periods in the life of any organization are important but some show evidence of greater progress and deal with broader issues than others. The present is such a time. Your executive and your committees have had a very exacting biennium. They need your help and support. For information on accommodation, transportation, registration, etc., consult your *Journal*. Unfortunately, many nurses do not subscribe to *The Canadian Nurse*, the official organ of the Canadian Nurses' Association. Those who do so might try a little missionary work and talk about the *Journal* and the biennial meeting to their friends. Nursing can only be as strong as the individual member and a vital, vigorous nursing body was never more needed than it is today.

Reports from Executive Meetings

An Executive meeting of the C.N.A. was held at the Metropolitan School of Nursing in Windsor, Ont., at the beginning of November. The following digest of the reports will give you some idea of the issues involved:

As you are already aware, the general secretary, Miss Gertrude Hall, spent much of her time in field visiting during the past year. She was much impressed with the welcome accorded her and the developments witnessed. In British Columbia, she visited eight chapters and addressed the student body in several schools of nursing. She also attended the annual meeting of the Registered Nurses' Association in Alberta, where she made a tour of many hospitals and addressed various student and staff groups. The annual meetings of the Registered Nurses' Associations of Manitoba, Saskatchewan, Nova Scotia, and P.E.I. also proved very interesting.

During these field visits, the general secretary made a point of interviewing various governmental and hospital authorities and a great deal of time was spent in interpreting nursing problems. Throughout Canada she found encouraging evidence that nurses individually and collectively are assuming great responsibilitity in trying to meet the many demands made upon them. There is a greater awareness of the need to seek the cooperation and support of other professional and lay groups in helping to solve the complex problems facing nurses and nursing.

The general secretary attended the sessions of the Economic and Social Council of the United Nations in Geneva when the resolution on the status of nurses was considered and accepted without revision. She accompanied the president to the Board of Directors meeting of the I.C.N. held in Brussels.

On request of the public relations counsel of the Canadian Medical Association, the general secretary submitted an article "As Others See Us" for the C.M.A. bulletin *On Call*. The article was printed and submitted to members of that association.

The Canadian Nurse Journal reported that a new contract has been entered into with Edwards and Finlay Ltd., Toronto, and that the new representatives began their work on September 1, 1951. They are very enthusiastic about the *Journal* as a medium of advertising. The advertising rates have been revised. The *Journal* has applied for and been accepted to membership in the Canadian Circulations Audit Board. The need for a field representative to interpret the use of the *Journal* as an educational tool was presented. Reference was also made to the convention issue which will be published in May, increased postage rates, and to the fact that *71* per cent of the members of the Canadian Nurses' Association do *not* subscribe to the *Journal*. How do they know what is happening in nursing circles?

Committee on Constitution, By-Laws and Legislation reported that, as authorized by the General Meeting, 1950, and instructed by the Executive Committee in meeting February, 1951, the Act of Incorporation and By-Laws has been printed and distributed.

Committee on Educational Policy reported that the committee had prepared a draft statement of an educational creed or policy for the consideration of committee members and recommended that: (1) the I.C.N. be urged to reproduce and make available their brochure on postgraduate education; (2) if the Executive Committee was unable to secure a suitable person for the position of educational secretary, a second executive secretary be appointed to carry on educational activities under the guidance of the general secretary; and (3) the evaluation of the Demonstration School be based on the purposes stated in the report submitted to the C.N.A. in December, 1946.

Committee on Institutional Nursing is proposing to set up an orientation program for staff nurses in hospitals and suggests that the committee might prepare a manual.

Public Health Nursing Committee has concentrated on: (1) stimulating interest in the report of the Study Committee on Public Health Practice in Canada; (2) securing articles for the Public Health Nursing Page of *The Canadian Nurse*. The committee raised, among others, the question of whether the association is perpetuating an artificial and undesirable division of nursing by the special pages; suggested that an attempt be made to study progress in public health nursing services since the previously mentioned study on public health practice in Canada had been completed.

Private Nursing Committee: The convener had recently been appointed and was attending her first meeting. She raised the question as to ways and means of interesting the private nursing group and establishing a better relationship between this group and other members of the profession.

Committee on Health Insurance has formulated broad principles upon which the committee is convinced that any future action by the nursing profession might be based. The members of the committee plan to apply these principles to the place of nursing in health insurance as outlined in the Draft Bill contained in the 1942 report of the Advisory Committee on Health Insurance and then to consider the place of nursing in any future legislation for health insurance.

Committee on Labor Relations suggests that (1) the functions and program of the committee be revised for the following reasons: (a) lack of regular meetings; (b) frequent change of personnel; (c) question as to the right of this committee to make important decisions; (2) all information on matters relating to collective bargaining, labor laws and registration, etc., be assembled by National Office; and (3) strong provincial committees on labor relations be maintained to take over the function of the national committee for each province or, in other words, that each province study its own situation and laws pertaining to employment practices, and keep well-informed on all labor relations questions. (4) Should a question arise necessitating national action, the provincial representatives or the chairman of each provincial labor relations committee might act as consultants on labor problems (a Dominion-Provincial conference idea).

Loan and Bursary Committee reports that three $500 loans have been made and that a fourth is under consideration.

Committee on Provision of Nursing Care reports that the C.N.A. is rapidly becoming involved in research. Three projects are under way or contemplated —the Structure Study, the Head Nurse Study, and the Evaluation of the Metropolitan School. In an attempt to define the total field of needed research and to achieve a unity in which specific research projects could find their place, a diagram of a research program for the association

was drawn up and presented to the executive:

Structure Study Committee reports that the draft report will reach the provincial associations in time for careful study prior to the spring Executive meeting.

War Memorial Committee reports that, as there was no apparent enthusiasm in France or Belgium for a French translation of the book on pediatrics, the project was abandoned. One hundred books and a set of anatomical charts were shipped to the University of Delhi School of nursing and several packages of used textbooks to another school of nursing in India. Books and charts are being sent to the new Ethiopian Red Cross School in Addis Ababa and to the new school in Paris—the first in France to offer post-graduate courses to graduate nurses in teaching, supervision and administration.

Report of Grand Council, F.N.I.F.: The president of the C.N.A., Miss Helen McArthur, was present at the meeting of the Grand Council. She reports that a program is evolving through which the objectives of the Foundation may be achieved. Mrs. R. Louise McManus presented the Florence Nightingale Foundation Council report. Miss Ellen Broe, director, F.N.I.F., was present at the meeting. A headquarters committee to act as coordinating committee of the executive staff was appointed as follows: the executive secretary of the I.C.N., the director of the F.N.I.F., and the associate executive secretary of the I.C.N.

The report of the F.N.I.F. Council points out that (1) it will be necessary to find $12,130 to meet the desired budget of $21,730 for 1952; (2) WHO has charged the I.C.N. with projects which have been referred to the F.N.I.F. for action; (3) in addition, the Council approved a further project as the educational program for the immediate future; and (4) while WHO has contributed towards these projects the budget still exceeds the funds in hand. The national associations were, therefore, asked to contribute an amount equal to one-third of their anhual I.C.N. dues during the next two-year period.

Canadian F.N.I.F. Committee reports that, due to expanding educational programs, nurses must find funds, in addition to those provided by WHO, to complete the projects undertaken by the F.N.I.F. and to ensure continuance of the present administration. The Grand Council, F.N.I.F., recommended to the Grand Council, I.C.N., that consideration be given at the next meeting to raising of dues in order to enable the work of the F.N.I.F. to be carried out. The committee expressed approval of the sum allotted to Canada—i.e., one-third of the annual affiliation fee due to the I.C.N. during the next two-year period. The committee also recommended that this allocation should be paid from the general funds of the C.N.A. It was further recommended that in the future the Committee on Educational Policy of the C.N.A. act as the Canadian F.N.I.F. Committee and that the present Canadian F.N.I.F. Committee be dissolved.

Data regarding nurses in Canada: Miss Agnes Macleod, C.N.A. representative to D.M.D.S.A.B., presented two proposed plans for conducting a survey of graduate nurses in Canada. Both assume that the assistance of interested agencies will be sought. The first proposal is for a survey conducted essentially by the C.N.A. for its own purposes with the additional objective of securing information desired by D.M.D.S.A.B., Civilian Defence and Department of National Health and Welfare. The alternative plan is for a joint survey conducted by the above agencies plus some information desired by the C.N.A. The purpose of the survey, the question of which plan to adopt, the type of questionnaire to be used, method of distribution, tabulation of data and relative expenditures involved are all questions demanding a great deal of consideration.

Through the Looking Glass

What do we see this month about nursing in our mirror—the press? Uniformed nurses of Quebec City formed a guard of honor at the Legislative Buildings for Their Royal Highnesses, Princess Elizabeth and Prince Philip; the preparation of nurses for A.B.C. warfare is proceeding at a rapid pace; B.C. nurses, 500 of them, recently attended an exposition designed to inform them on

advances in such fields as premature baby care, poliomyelitis, etc.; Ontario nurses in October held an institute for registry personnel; many scholarships and fellowships have been awarded for study in Canadian and some in American universities; one student from Newfoundland is going all the way to Kentucky to study midwifery; one chapter of a registered nurses' association has awarded a scholarship to a prospective student nurse and the Red Cross has awarded two scholarships of $1,250 each for study at the University of Toronto School of Nursing; Kingston General Hospital School of Nursing has had to enlarge their classroom facilities to admit the largest class on record; the Winnipeg General Hospital School of Nursing is admitting male students. Incidentally the reaction of the press to the admission of male students to the nursing school was decidedly favorable.

I.C.N. News

Miss Ellen Broe is now established as director of F.N.I.F. in her office at 19 Queen's Gate and is busy developing the future program of the Foundation.

The *I.C.N. News Letter* for the first time has attached a brief page issued by the Foundation. It contains the information that preparations for the Study of Advanced Nursing Education, which is to be undertaken for WHO, are well under way and that the F.N.I.F. has established contact with the National Foundation for Educational Research in England and Wales.

Mlle Clamageran, president of the National Association of Trained Nurses of France, represented the I.C.N. at the meeting of the General Assembly of the United Nations that opened in Paris on November 6, 1951.

Miss Norena Mackenzie, educational director of the Montreal General Hospital, was present as a member at the Second Session of the Expert Committee on Nursing of WHO which met in Geneva, October 15-20, 1951. The report of the committee will be presented at the next meeting of the WHO Executive Board in January, 1952, and, if approved for publication, will appear in the WHO Technical Series. A report of the First Session has already been published. The resolutions contained therein are in process of being implemented and it is extremely important to our profession that leading nurses in all countries are aware of the contents of this document, in order that they may bring appropriate resolutions and recommendations to the notice of their governments.

The physiotherapists have formed a world federation for physical therapy. The inaugural meeting took place in Copenhagen on September 8, 1951. Canada is a member.—*News Letter No. 8, I.C.N.*

Orientation et Tendances en Nursing

CONGRÈS BIENNAL

Le congrès biennal de 1952 se tiendra à Québec au Château Frontanac du lundi, le 2 juin, au vendredi, le 6 inclusivement. Pourquoi parler en janvier d'un événement prenant place qu'en juin? Bien, le temps file si rapidement qu'il faut s'y prendre bien à l'avance pour obtenir un congé et faire les économies nécessaire au voyage.

Si vous êtes une jeune diplômée vous désirerez assister à ce congrès afin d'apprendre ce qu'accomplit l'Association des Infirmières du Canada, ce que vous pouvez attendre d'elle, et ce que vous pouvez faire pour aider votre association à préparer l'avenir. Si vous êtes une infirmière d'expérience, l'on a besoin de votre aide pour formuler la politique de l'association.

Tous les périodes dans l'existence d'une association sont importantes mais certaines

sont marquées par des progrès et d'autres par des difficultés qu'il faut surmonter. Nous en sommes à une période difficile. Durant ces deux dernières années votre Conseil Exécutif et vos comités se sont livrés à un travail astreignant et ils reclament votre aide et votre support.

Les renseignements concernant le congrès paraîtront dans notre *Journal*. Malheureusement plusieurs infirmières ne sont pas abonnées au *Canadian Nurse*, le journal officiel de l'A.I.C. A celles qui le sont, peut-on demander un travail d'apôtre? De parler du *Journal* et du congrès à leurs compagnes. La profession a la force de chacun de ses membres et un corps professionnel fort vigoureux n'a jamais été plus nécessaire qu'actuellement.

Rapport de l'Assemblée de l'Exécutif

Une assemblée du Conseil Exécutif de l'A.I.C. a eu lieu à Windsor, Ont., au "Metropolitan School of Nursing" au début de novembre. Le résumé suivant vous donnera une idée des points discutés:

Vous êtes déjà au courant que Mlle G. Hall a visité, à travers le pays, les organisations professionnelles. L'accueil qu'on lui a fait et le développement qu'elle a pu constater l'on vivement impressionnée. En Colombie-Britannique, elle a visité huit chapitres et a rencontré les étudiantes de plusieures écoles. Ella a aussi assisté à l'assemblée annuelle de l'Association des Infirmières Enregistrées de l'Alberta. Dans cette province elle a visité de nombreux hôpitaux et a adressé la parole à plus de dix groupes d'étudiantes et de membres du personnel des hôpitaux. Elle a également assisté aux assemblées annuelles de l'association des infirmières enregistrées du Manitoba, de la Saskatchewan, de la Nouvelle-Ecosse, et de l'Ile-du-Prince-Edouard. Durant ces visites la secrétaire générale s'est fait un devoir de rencontrer les autorités des gouvernements et des hôpitaux et une grande partie de son temps a été employé à discuter des problèmes du nursing. Elle s'est rendue compte, que partout à travers le Canada, il est évident que les infirmières, individuellement et collectivement, assument de grandes responsabilités en essayant de répondre à toutes les demandes qui leur sont faites. Dans les divers milieux professionnels l'on est plus conscient de la nécessité de demander la coopération et le support des divers groupes professionels et autres pour aider à trouver une solution aux problèmes complexes du nursing et auxquels les infirmières doivent faire face.

La secrétaire générale a assisté aux séances du Conseil Economique et Social des Nations-Unies à Genève lorsque la résolution concernant le status des infirmières fut consideré et accepté sans revision.

Elle accompagna la présidente à la réunion du Bureau des Directeurs du Conseil International des Infirmières à Bruxelles.

La Canadian Medical Association a demandé à la secrétaire générale d'écrire un article pour leur journal—"Comment les Autres Nous Voient?" C'est l'opinion des infirmières sur les médecins. Cet article fut publié dans le bulletin du C.M.A.

Le Journal "Canadian Nurse": Du rapport du *Canadian Nurse* l'on peut noter les faits suivants: Un contrat vient d'être signé avec Edwards and Finlay Ltd. de Toronto, chargé de recueillir des annonces pour le *Journal*. Ils jugent la revue excellente et montrent de l'enthousiasme dans leur travail. L'on a présenté la nécessité d'envoyer une réprésentante à travers le pays dans le but de faire connaître comment utiliser le *Canadian Nurse* dans l'enseignement. Il fut fait mention du numéro spécial du congrès lequel sera publié en mai; de l'augmentation du taux des postes et du fait que 71 pour cent des infirmières ne sont pas abonnées au *Canadian Nurse*. Comment peuvent-elles être au courant des événements professionnels?

Le Comité de Législation rapporte que, selon l'autorisation donnée à l'assemblée générale de 1950 et sur l'ordre du Comité Exécutif, la loi de l'incorporation et les règlements furent publiés et distribués.

Des rapports furent aussi présentés par les comités suivant:

Politique en Matière d'Education: (1) Demande de reproduire, pour le bénéfice des infirmières canadiennes, la brochure publiée par le Conseil International des Infirmières sur l'instruction post-scolaire; (2) si une candidate ne peut être trouvée pour le poste de secrétaire éducatrice, qu'une deuxième secrétaire soit nommée pour faire ce travail sous la direction de la secrétaire générale; (3) que l'évaluation de l'école de démonstration de Windsor soit faite d'après les buts proposés lors du rapport soumis à l'A.I.C. en 1946.

Comité des Infirmières des Hôpitaux: Le comité se propose d'établir un programme d'orientation et suggère que le comité prépare un manuel à cet effet.

Comité des Infirmières de l'Hygiène Publique:

Le travail de ce groupe a été: (1) de stimuler l'étude du rapport sur "La Pratique de l'Hygiène Publique au Canada"; (2) d'obtenir des articles pour la page de l'hygiène publique dans le *Canadian Nurse*. Le comité se demande, en publiant une page spéciale en hygiène publique, s'il ne créé pas une division artificielle dans le nursing.

Comité des Infirmières du Service Privé: La nouvelle convocatrice se demande quels sont les moyens à prendre pour établir des relations plus étroites entre son groupe et les autres membres de la profession.

Comité des Assurances de Santé: Le rapport de ce comité contient des principes sur lesquels pourront s'appuyer les infirmières en considérant la place que doit occuper la profession advenant l'établissement des assurances de santé.

Comité des Relations du Travail: Le comité suggère: (1) une revision des fonctions de ce comité; (2) que tout les informations concernant les conventions collectives, les lois du travail, etc., soient compilées au secrétariat général; (3) que dans chaque province des comités des relations du travail soient formés—en d'autres termes, que chaque comité étudie sa propre situation et ses propres lois et se tiennent au courant de toutes les questions du travail. Les convocatrices de ces comités provinciaux pourront au besoin agir en qualité de conseillers.

Comité des Prêts et des Bourses a rapporté que trois prêts de $500 ont été fait et que l'on considère une quatrième demande.

Comité des Mesures pour Assurer le Soin des Malades: Des recherches très actives se poursuivent dans ce domaine—l'étude des fonctions et relations de l'A.I.C., l'étude des attributions de l'hospitalière, et l'évaluation de l'école d'infirmière de Windsor.

Le Comité de l'Etude des Fonctions et Relations de l'A.I.C.: rapporte que le résultat de cette étude parviendra sous peu aux associations provinciales. Le rapport sera présenté assez tôt pour en permettre l'étude détaillée avant la réunion du Comité Exécutif du printemps.

Le Comité du Souvenir rapporte que devant le peu d'enthousiasme manifesté en France et en Belgique à propos de la traduction d'un livre sur la pédiatrie, que le projet a été abandonné. Deux envois de livres et des cartes anatomiques ont été adressés à deux écoles d'infirmières aux Indes. Des livres et des cartes ont été aussi envoyés à la nouvelle école de la Croix-Rouge à Addis Ababa et à Paris à la première école en France, à offrir aux infirmières des cours post-scolaires en enseignement, surveillance et administration.

Rapport du Conseil de la Fondation International Nightingale: La présidente de l'A.I.C., Mlle H. McArthur, assista à la réunion du Grand Conseil. De ce rapport signalons le travail confié à cet organisme par le Conseil International des Infirmières à la demande de l'O.M.S.; malgré l'aide financière de l'O.M.S. l'excédant des dépenses prévus pour mener à fin les projets d'éducation de la fondation; moyens pour obtenir des revenus supplémentaires.

Recensement des Infirmières

Mlle Agnes Macleod, à titre de représentante de l'Association des Infirmières du Canada sur le Conseil des Consultants Médicaux et Dentaires en matière de défense (ou la D.M.D.S.A.B.), présenta deux plans pour un relevé des infirmières du Canada.

Dans le premier plan le relevé sera fait par l'A.I.C. en plus des renseignements qui leur seront particulièrement utiles. L'on demandera ceux suggerés par la D.M.D.S.A.B., la défense civile, et le Ministère National de la Santé et du Bien-Etre. L'autre plan est l'inverse du premier le relevé sera fait par les organismes du gouvernement déjà mentionnés et les renseignements désirés par l'A.I.C. seraient demandés.

Le but du relevé, les questions à poser, la compilation, les coûts, etc., sont des questions demandant considération.

Coup d'Oeil Ici et Là

Les étudiantes et les infirmières des hôpitaux de Québec, rangées autour du parlement, fournèrent une garde d'honneur lors de la visite de La Princesse Elisabeth et du Duc d'Edimbourg. Les cours sur les Aspects du Nursing dans la Guerre A.B.C. se donnent à travers tout le pays. En Colombie-Britannique 500 infirmières ont visité une exposition ayant pour but de les renseigner sur les traitements nouveaux dans le soin des prématurés, de la poliomyelite, etc. En Ontario, des journés d'études furent organisées pour le personnel des registres. Plusieurs infirmières ont bénéficié de bourses d'études et sont actuellement dans des universités canadiennes ou américaines. Une infirmière de Terre-Neuve s'est rendue aussi loin que le Kentucky pour y étudier l'obstétrique. La Croix-Rouge a accordé deux bourses d'études de $1,250 chacune à deux infirmières inscrites

à l'Université de Toronto. L'école d'infirmières de l'Hôpital Général de Kingston a du élargir ses cadres afin d'accommoder la plus grande classe d'étudiantes jamais inscrite.

La réaction de la presse a été favorable à l'admission d'étudiants du sexe masculin dans les écoles d'infirmières.

Mlle Norena Mackenzie, directrice de l'éducation au Hôpital Général de Montréal, assistait à titre de membre à la seconde session du Comité des Experts en Nursing de l'O.M.S., tenue à Genève en octobre.

CHEZ LES NÔTRES

L'admission dans les écoles d'infirmières de la province de Québec a dépassé un record sans précédent — 671 jeunes filles ont été admises à l'étude de la profession en septembre.

Un guide à l'usage de nos écoles d'infirmières, contenant les articles de la loi, des règlements, et la politique adoptée concernant les écoles, a été publié et distribué.

A LA PEINE ET À L'HONNEUR

La présidente de l'Association des Infirmières de la Province de Québec, Mlle A. Martineau, qui se dévoue si généreusement pour les infirmières, recevait l'insigne honneur d'être invitée, à ce titre, au dîner offert par la ville de Montréal à Leurs Excellences la Princesse Elisabeth et au Duc d'Edimbourg lors de leur visite.

International Council of Nurses Board of Directors Meeting

AT THE REQUEST of the president of the Canadian Nurses' Association, with whom I attended all the meetings of the Board of Directors, International Council of Nurses, in Brussels, August 18-25, 1951, I shall give a résumé of the following reports submitted by the various committee chairmen:

NURSING SERVICE

Mrs. B. A. Bennett, chairman, submitted an excellent report. It contains a lengthy list of the principal factors which have a bearing on the increased demand for nurses, with a corresponding list of the measures taken to increase the numbers of nursing personnel; wastage of nursing personnel and methods adopted to prevent wastage; the methods used to economize in numbers of nurses are also listed.

The chairman stated that during the next two years this committee will attempt to formulate acceptable standards of nursing service. They have asked national associations to keep the committee informed of and supplied with the details of any studies undertaken which relate to nursing service.

Mrs. Bennett also represented the I.C.N. at the International Hospitals Federation conference held in Brussels from July 15-31, and commented briefly on this conference.

EDUCATION COMMITTEE

Miss Ruth Sleeper, chairman, reviewed the recommendation made by the Grand Council in Stockholm, Sweden, in 1949, namely:

> That the Education Committee, with the help of the National Committees in all member countries, should study visual aids for use in teaching in schools of nursing, as a means of improving the teaching of nursing.

As a result of the suggestions received from the members of her committee, Miss Sleeper prepared suggestions for the national committees undertaking a study of visual aids. The plan included a study of visual aids available in each member country. The committee plans to work closely with the Films Section of the World Federation for Mental Health and it intends to prepare—for submission to the next meeting in 1953—schedules of minimum essential equipment for teaching units in schools of nursing.

ECONOMIC WELFARE COMMITTEE

In the absence of Miss Florence N. Udell, chairman, Miss Daisy Bridges, executive secretary (I.C.N.), gave the report which referred to the recommendation of the Expert Committee on Nursing, World Health Organization, suggesting an investigation of the working conditions of nurses—including salaries, hours, health conditions, and personnel policies. To obtain this information, it was suggested that the assistance of the International Council of Nurses, as well as the help of other bodies, should be sought. It was explained that the work of the Economic Welfare Committee assumed additional importance in the light of this recommendation.

A lengthy questionnaire was circulated by the committee to 28 national associations. The 20 replies received produced an overwhelming wealth of material. It was pointed out by the chairman that the study of all this material and the drawing up of a comprehensive report—which will contain not only a comparison of the relative facts but will require careful tabulation in some cases—is taking an equally long time and cannot be done in committee by a group of members all living in different countries. The chairman pointed out that a very great deal of work has yet to be carried out before any really conclusive suggestions or recommendations can be made, having in mind that a final report must be prepared in such a way that it may be made available to the World Health Organization, to assist in their investigations.

Miss McArthur and I had discussed this report before its presentation and were of the opinion that the chairman should have the assistance of experts, such as statistical analysts, to compile and analyze the replies and to help, if necessary, with the preparation of the final report. This suggestion was put forward by Miss McArthur and was accepted. It is expected that, when the final report has been completed, member associations will find it of real value.

ETHICS OF NURSING COMMITTEE

Unfortunately, Miss Craven, the chairman, was unable to present her report in person. The report contained a questionnaire on Nursing Ethics which it is proposed to send to member countries. The questionnaire raised queries concerning the teaching of nursing ethics in the basic curriculum. Several members of the Board of Directors expressed concern at what was obviously an elementary approach to this subject. It was agreed that an international Code of Ethics, befitting the nursing profession, should not be limited to regulations concerned with disciplines but should consist of broad principles.

INTERNATIONAL NURSES' SCREENING BOARD

In accordance with the decision taken by the International Council of Nurses in May, 1950, Miss Alice Sher, assistant executive secretary, has taken over from the International Refugee Organization the professional register for qualified nursing personnel among the displaced persons and is responsible for maintaining and amending the register. She continues (a) to assess the credentials of refugee nurses whose professional status has not been established; (b) to give professional advice to refugee nurses; (c) to deal with all relevant correspondence.

A total of 1,292 qualified personnel and 2,592 semi-professional personnel has been cleared by the International Nurses' Screening Board. Miss Sher reported that nursing registration authorities from all over the world are directing inquiries to the I.C.N., in order to ascertain the professional background of the foreign trained nurses now applying for registration in their new country of residence.

In concluding her report, Miss Sher stated that the cooperation between the I.C.N. headquarters and the nursing authorities responsible for nurse

registration all over the world is increasing daily. Through the exchange of knowledge and the manifestation of a sympathetic understanding of the various problems with which the refugee nurse is faced, the nurses of the world have achieved an objective as yet not reached by any other profession.

EXCHANGE OF NURSES COMMITTEE

Miss M. Kruse, chairman, reviewed the work of her committee since its formation in 1948. She emphasized that the word "exchange," as used by this committee, refers only to the cooperation among the national nurses' associations for the purpose of arranging employment and planning studies in other countries for their members, irrespective of whether such arrangements are reciprocal. It was stated that the committee had been unable to find a more appropriate word.

A card index has been set up and is kept at the I.C.N. headquarters; each national association is required to keep its own card index. The cards show the possibilities and conditions of obtaining employment and study in the various countries.

The Exchange Committee has prepared directives for the guidance of national organizations, concerning arrangements for employment and planning studies. It is hoped that this material may be printed in pamphlet form in three languages, as approved by the I.C.N.

The committee did not consider it expedient to accept the suggestion put forward by the Exchange of Nurses Committee of the C.N.A. to simplify the present forms. When we learned that several countries are employing additional professional and clerical staff to handle the increased correspondence, resulting from the exchange of nurses program, it was readily understood that we in Canada are not in as favorable a position at the present time to undertake an expanding program such as this.

National nurses' associations are now requested to report to I.C.N. headquarters by the end of each calendar year on the number of foreign nurses who have been employed, or for whom studies have been planned, in the country concerned, and on the number of their members for whom exchange privileges have been obtained in other countries.

Reporting on the extent and possibilities of exchange, Miss Kruse had this to say:

> It is a matter of fact, that the impression one has from the reports on the exchange of nurses between the various countries is far from being a true impression, as the nurses' associations in several of the countries do not effectively supervise the employment of foreign nurses. In view of the fact, however, that this was the first attempt to obtain from the nurses' associations a complete survey of the extent and possibilities of the international exchange of nurses, one cannot but admire the effort made by many of the national organizations to give as accurate information as possible of the exchange now being carried out.

As to numbers, Sweden leads both in the case of employment and planning of studies for foreign nurses (464 cases of employment and 139 studies), whereas Denmark has arranged the greatest proportion of employment abroad (460) and the greatest number of studies abroad (74) for its own members. A somewhat more exact picture of the activities of the organizations may be obtained by considering them in proportion to the number of members of the individual organizations. Here New Zealand leads with 10.8 per cent in the case of employment of foreign nurses, whereas Sweden, also in proportion to its own number of members, has arranged the greatest number of studies for foreign nurses (1.2 per cent).

As regards employment arranged by the organizations for their own members, the Netherlands leads with 10.3 per cent. and Ceylon has proportionately arranged the greatest number of studies for its own members (6.9 per cent). While in most countries (apart from Canada and the United States, where employment has also been arranged in visiting nursing and public health) the arrangements have been limited to hospital work of various kinds (general, children, mental, tuberculosis, midwifery, etc.), the studies apparently cover all fields of nursing—public health, administration, and education playing an especially prominent part. Of a particularly international character were two group excursions in Denmark with "Tuberculosis Care" as their main subject attended by nurses from 17 countries. Moreover, Canada, Great Britain, Sweden, and the United States seem able to offer unusually varied openings for study within the different specialties.

The initiative taken during the visit of the president, Miss Gerda Höjer, to the United States in the autumn of 1950 deserves special notice. At a conference held at the Brooklyn Visiting Nurses' Association between the president of the I.C.N. and representatives of the American Nurses' Association, an internship program was worked out for foreign public health nurses on a supervisory scale. If such programs could be offered to a greater extent, the international exchange of nurses might reach a level of real benefit to international nursing. The committee wishes to express to the president of the I.C.N., the Brooklyn Visiting Nurses' Association, and the A.N.A. its appreciation of that initiative.

It has been of great interest to the committee, through the work with the international exchange of nurses, to become acquainted with the work of similar kind executed by other international organizations, as WHO, UNESCO, ILO, etc. The annual surveys sent out by UNESCO and ILO also mention the initiative which a few of the nurses' organizations have taken in this respect. The reason why not all the cases have been reported on is, no doubt, either that the effort taken by the nurses' associations in question has been unknown to the two organizations or that the nurses' associations have not answered the questionnaires sent to them. However, as it will undoubtedly be important that, in this respect, the I.C.N. works as closely as possible with the other international organizations, the committee takes the liberty to recommend that both UNESCO and ILO be made acquainted with the work of the I.C.N. in that field.

WHO Nursing Section has been approached by I.C.N. headquarters with the request that when studies are required for WHO nurse scholars, the national nurses' associations in the countries concerned shall be informed of the prospective visit. Some of these scholars are outstanding nurses and the fact that national nurses' associations have not been informed in time of their visits has often resulted in less valuable programs being planned for them, than for other nurses whose studies have been arranged in the normal way through cooperation between the national nurses' organizations concerned. Moreover, the information obtained through Miss Olive Baggallay, nurse consultant in WHO, concerning the exchange of social welfare personnel, organized with the assistance of the United Nations, has been extraordinarily inspiring to the committee. Certainly, it is admitted that the work with the international exchange of nurses is not yet sufficiently far advanced to make it practicable for the I.C.N. to approach the United Nations for assistance in a scheme of exchange for nurses; but, on the other hand, during the short period for which the I.C.N. has undertaken responsibility for the exchange, the work in this direction seems to have developed so satisfactorily that time should not be distant when we may apply to the United Nations for its support in the matter.

Conclusion: As it appears from this report, the committee has tried

1. to procure a complete and as accurate a survey as possible of the international exchange of nurses now being carried out *and*
2. to solve a number of small questions in connection with the recommendations carried by the Grand Council in Stockholm in 1949.

Through that work it has been realized that the international exchange of nurses, as to extent and standard, cannot as yet be considered satisfactory. The reasons are thought to be:

1. that an approved international definition of the concept of nursing does not exist;
2. that this being so, the nurses of one country are not automatically accepted for registration in another country or, if accepted for registration, are not offered positions of equivalent status.

If these assertions are true, a satisfactory development of the international exchange of nurses will greatly depend on the practical results of the work of the I.C.N. Education Committee and Nursing Service Committee.

In the opinion of the committee the policy of the I.C.N. Membership Committee will also influence the exchange of nurses. However, by work prepared with care and initiative on a long-term policy the exchange of nurses among the countries will become a means of serving the high aims of the International Council of Nurses.

Having prepared this report, including the card-index, which covers the present possibilities of the international exchange of nurses, we consider the task with which we were charged at the Board of Directors' meeting in London, completed, and so take the liberty to move dissolution of the committee.

The Board of Directors did not accept the latter recommendation, for the present at least, as it was felt that the committee should still be available for consultation if and when required.

Membership Committee

The progress report contained among the recommendations one concerning the relationship of such countries as Bulgaria, Czechoslovakia, Estonia, Hungary, Poland, Roumania, and Yugoslavia. This was referred to the Committee on Constitution and By-Laws for further study. The executive secretary was also requested to explore the possibility of establishing relationship, with a view to future affiliations, for some 20 countries.

Special and Temporary Committees

Headquarters: The International Council of Nurses has been fortunate in being able to enter into an agreement with the British College of Nurses for an extension of the premises already occupied at 19 Queen's Gate. A large room on the second floor has been set aside for the use of the director of the Florence Nightingale International Foundation; it is furnished with the furniture brought from 45 Gloucester Place. The annual rental for the I.C.N. headquarters, including the F.N.I.F., is now £850.

Ways and Means Committee: Unfortunately, the chairman, Miss Lucy Germain, was unable to attend the meeting and it was once again my responsibility to act as deputy chairman and to present the report, which contained the following recommendations:

1. That each member association be asked to declare the sum of money it can contribute annually to the support of the Florence Nightingale International Foundation.

2. That such funds should be over and above the dues paid to the International Council of Nurses.

3. That such funds should be raised at the discretion of the respective member associations in any way that seems desirable. This may be a stated sum per capita and/or a budgetary item and/or raised by popular method in different groups on local and state level, etc.

4. That each member association be asked to make a contribution *now* toward the program of the Florence Nightingale International Foundation if it hasn't already made such an allocation since the meeting in Stockholm in 1949.

5. That currently, it is untimely to approach foundations for financial assistance and, until such time as the program of the Florence Nightingale International Foundation has crystallized, the major part of the cost of the program be borne by nurses themselves.

6. That the Ways and Means Committee be kept informed of any comtemplated programs with the estimated cost of each and of any suggestions as to implementation.

Committee on Relief: The chairman suggested that the need for the existence of a Relief Committee in the I.C.N. should be reviewed and that, if the committee is dissolved, the responsibility of reporting to the Board from time to time on existing needs among nurses and of bringing these needs to the attention of individual nurses' associations who are in a position to help shall be entrusted to the executive secretary of the I.C.N. The latter suggestion was accepted by the Board of Directors.

Gertrude M. Hall
General Secretary-Treasurer,
Canadian Nurses' Association

Report of the Nursing Service Committee

The report is related to information collected during the period June, 1949, to June, 1951, and is an interim or progress report of the work of the committee. A further report, embodying and enlarging on the main features presented here, will be prepared within the next two years for presentation at the Quadrennial Congress of the I.C.N.

The main facts have been assembled by correspondence. The chairman has exchanged letters with the members of the committee, presidents of the national nurses' associations, and with the national associate representatives. Information was sought generally on the supply of and demand for nursing personnel.

In the main the supply of nursing personnel in most countries has improved but in very few countries has the improved recruitment made any appreciable reduction in the demand for nurses. The position in tuberculosis hospitals and sanatoria, mental hospitals, and hospitals and institutions devoted to the care of old people remains very serious. We suggest that the "demand" for nurses requires some explanation. It should, we feel, be sub-divided into (a) the demand and (b) the need:

(a) *The demand.* The demand for nursing personnel is to be taken as the number of vacancies that could be filled at once if nursing personnel were available. This, if assessed correctly, should be viewed against the background of (i) the total population, (ii) the working population of a country, (iii) the numbers of educated men and women from whom recruitment could be made, and (iv) other occupations and professions demanding a supply of educated people. In this way a realistic figure could be obtained. An estimated demand figure can be very misleading. (One country had, for some time, thought the number of nurses required to bring the nursing force up to strength was in the region of 58,000. A special questionnaire was designed and assistance given by nurse experts in its completion. The figure obtained from the special questionnaire reduced the demand from 58,000 to 38,000.)

(b) *The need.* The need for nurses is a very different matter and presumes that a country has examined the needs of the people for nursing service, both preventive and curative.

The division of the demand into an immediate and realistic figure and the need for nursing service is related to the terms of reference of the Nursing Service Committee. Details of numerical demands in relation to the world would not, we feel, be very helpful for consideration by individual countries. Assistance could be given to any country asking for it on successful ways and methods of obtaining a realistic figure of immediate demand. The circulation of material received by the Nursing Service Committee on successful methods of supply, prevention of wastage, and economic use of personnel could be made.

With regard to the need for nursing personnel, it is hoped during the next two years to prepare a report and make recommendations for acceptable standards of nursing service in relation to the various different branches of nursing.

1. *Principal factors which have a bearing on the increased demand for nurses:*

(a) An increasing number of hospital patients—due to the effects of health education programs which result in patients seeking advice at an early date

with consequent treatment and hospitalization.

(b) Widely increased use of prepaid, assisted, and free hospitalization.

(c) Earlier diagnosis and treatment of mental disorders, cancer, circulatory diseases, and tuberculosis.

(d) Expanding and improving public health and hospital services.

(e) Expanding and improving industrial nursing services.

(f) The complexity of clinical treatment—e.g., antibiotics. (This applies to treatment given in hospital and the people's own homes.)

(g) Extensive war pensions nursing services (known in some countries as veterans administration nursing services) for the treatment of the sick due to war illnesses and injuries.

(h) Progressive methods of surgery and early ambulation of patients, resulting in a more rapid turnover and a larger number of acutely ill patients at any given time.

(i) Improved care of the aged and infirm and increasing research in geriatrics.

(j) The need to expand nursing staffs in all branches of nursing in countries which find it necessary to develop defence programs.

(k) Encouragement of post-graduate study by national nurses' associations and, in some instances, governments.

(l) Post-graduate study sought by individual nurses, probably due to a desire to seek special training not covered in the basic course and the desire of nurses to equip themselves for higher posts, and possibly the reluctance of some nurses to undertake general duty or first level public health positions and to accept responsibility. This reluctance results in numerous post-graduate courses being taken immediately after the basic training. It is thought that, apart from the desire to equip themselves for higher posts, many nurses are inclined to cling to further training and prolong the "student status" because of the lack of instruction in the basic course on such subjects as ward management and other forms of supervision.

(m) Migration of nurses to other countries, frequently to those from which there is little, if any, return flow of graduate nurses. (One country reports a loss of over 50 per cent to other countries.)

(n) Attempts to achieve student status, freeing the student from repetitive, housekeeping, and domestic work in hospitals; this increases the demand for graduate and practical or assistant nurses.

(o) Shortage of young people in the age groups from which students are obtained. Wastage of school-girls before an adequate education has been completed. (Canada reports that many girls discontinue their education between Grade VI and Grade XI (Grade XI is University Matriculation). Twenty-one per cent of all girls in school discontinue education between Grade VII and IX; 30% of all girls in school discontinue education in Grade X; 22% of all girls seek employment at the end of Grade XI; 27% go on for advanced study. Therefore 49% of Canadian women have sufficient preparation to enter university; it will be noted, however, that 22% of this group sought *employment* and, of the remaining 27%, only 10% entered nursing.)

(p) Increased hospitalization due to poor housing conditions; also to lack of domestic help.

(q) Growth of population.

(r) Economic prosperity.

2. *Measures taken to increase the numbers of nursing personnel:*

(a) New schools of nursing have been established in a number of countries.

(b) Additional numbers of students have been taken into existing schools.

(c) Pre-nursing courses at schools. (One country allows a three months' concession in training for successful students.)

(d) Propaganda related to the nursing profession has been undertaken in a considerable number of countries and includes the use of pamphlets, posters, films, and radio. Vocational guidance officers and careers mistresses of secondary schools are kept supplied with literature.

(e) Many countries are increasing their number of male nurses and male students. (In one country male nursing personnel represents 15½ per cent of the total.)

(f) Part-time graduate nurses and auxiliary nurses are being used with

great benefit to hospitals and other nursing services.

(g) Improvement of economic conditions for graduate nurses is reported from a number of countries.

(h) Training allowances granted by governments to students have brought about a marked increase in the number of students.

(i) Countries report the immigration of graduate nurses from other countries.

(j) Intensive courses of training for experienced auxiliary workers.

(k) Compulsory courses of training for nursing attendants.

(l) An increasing number of schools for assistant nurses (practical nurses).

(m) Block and study day systems of education are popular and encourage more students to enrol.

(n) Employment of commercial cleaners to free nursing personnel from all household and domestic work.

(o) Registered midwives and registered maternity nurses in one country receive six months' concession on general training.

(p) One-year intensive course of training for psychiatric nurses.

(q) Three months' intensive course of training for nurses from other countries—e.g., including teaching of the Hebrew language in Israel.

(r) Endorsement of Hospital Training Certificate after completion of one year as a staff nurse.

(s) Bursaries for post-graduate training in tuberculosis, plastic surgery, neurosurgical nursing and infant welfare work.

(t) Refresher courses for ward, tutor, district and operating theatre sisters.

(u) Staff education programs.

3. *Wastage of nursing personnel is stated to be due to:*

(a) Inadequate salaries for graduate nurses.

(b) Economic difficulties in many countries preventing the employment of graduate nurses.

(c) Marriage is reported as being responsible for high wastage in many countries, particularly in countries where prosperity is returning.

(d) Difficulty in some countries in finding posts for graduate nurses because private hospitals are staffed by religious nursing orders. (In one such country it is known that in a private hospital, run by a religious nursing order, there is at the present time only one night sister for 1,100 patients.)

(e) No reciprocity between certain countries, precluding the use of graduate nurses from countries with a sound training and necessitating their employment as nursing orderlies or auxiliaries.

(f) Failure in examinations, particularly the preliminary examinations, embodying the basic sciences.

(g) Unnecessary restrictions of free time. Student nurses expected to be in the nurses' residence by 10:00 p.m.

4. *Methods adopted to prevent wastage:*

(a) Some countries are able to report very careful selection of students.

(b) Certain countries report careful health examinations before acceptance for training and continued health programs for students and graduates.

(c) Improved residences.

(d) Improved working conditions, including shortened duty spans.

(e) Education of the public on the value of nursing as a career.

(f) Refresher courses and staff education programs for graduate staff help to retain nurses in hospitals after the completion of training.

5. *Methods used to economize in numbers of nurses:*

(a) Extensive use of auxiliary grades.

(b) Use of central supply rooms and central dressing and transfusion services.

(c) "Training Within Industry" methods applied to the nursing services.

(d) Wider use of occupational therapists in mental hospitals reduces the number of nurses required.

(e) Wider use of ward secretaries.

6. *Outstanding features of the reports:*

(a) There appears to be wide use of auxiliary nursing personnel. Great concern is shown by some countries because the shortage of graduate nurses and the attempt to achieve student status necessitates the employment of many different auxiliary grades. An attempt is being made in a fairly large number of countries to license all those who contribute towards the nursing care of the patient. Attempts are being made to train and license practical or assistant nurses. The time taken to train this grade varies.

(b) Various methods of the selection of students for training are being undertaken. Some countries report that by better selection of students they have been able to reduce their wastage.

(c) Research into the right use of different grades of nursing personnel is being undertaken in a few countries.

(d) Tuberculosis nursing continues to be a grave difficulty. Case-finding measures, such as mass radiography and the examination of contacts, increase the number of patients needing home care and hospitalization.

(e) Advances made in the care of the aged, the infirm, and the chronic sick highlight the need for expert care in homes, hostels and institutions.

(f) The proportion of patients admitted to mental hospitals on a voluntary basis is increasing. There has been development in mental hospitals of ancillary methods of treatment such as occupational, physical, and recreational therapy. As well as being of great value to the patients these forms of treatment are an indirect help in reducing the pressure on depleted nursing staffs.

Acceptable Standards of Nursing Service

During the next two years the Nursing Service Committee will attempt to formulate acceptable standards of nursing service and, in this connection, would be glad to receive details of any studies undertaken by national nurses' associations and/or by individuals, if the reports made by individuals have the approval of the national nurses' association concerned. It is felt that studies relating to the following would be useful:

(a) Statements of specific functions of auxiliary workers, auxiliary workers being defined as workers in nursing services who carry out duties necessary to the support of nursing, including minor services to the patients, but who are neither professional nor recognized grades of assistant nurses or practical nurses.

(b) Standards of nursing service stated or adopted in all branches of preventive and curative nursing. The health needs of a country are, of course, influenced by the living standards of the people, by cultural and economic developments and by national habits. In a country where living standards are comparatively low we assume that any qualified nursing service would be helpful, even if not of the standards which would be labelled "acceptable" in a more advanced country. We would, therefore, like to have details of standards adopted by national nurses' associations or by governments in all member countries of the I.C.N.

The Nursing Service Committee would be glad to have guidance from the Board of Directors on cooperation with the Nursing Section of the World Health Organization Much useful information has been collected by both bodies. In order to prevent duplication in the collection of material and to obtain the maximum of benefit from the work it is felt that both bodies should be aware of each others projects and opportunities made for discussion by respective representatives.

Bethina A. Bennett
Chairman of Nursing Service Committee
International Council of Nurses

Cumulative Index Ready

The American Journal of Nursing has published a new Cumulative Index covering the material that has been published in the 60 issues from January, 1946, to December, 1950. This new 183-page edition lists a wealth of information on a very wide range of subject matter. Altogether, there are more than 30,000 references listed in this compilation. The postpaid price is the same on orders from Canada as from the United States—***$3.00 per copy***. Orders should be addressed to *The American Journal of Nursing, 2 Park Ave., New York City 16.*

Three new countries were granted national associate status by the I.C.N. when it met in Brussels last August. These countries were Northern Rhodesia, Jamaica, and Trinidad.

Student Nurses

Acute Osteoarthritis

Gladys Hartley

Mrs. Felsen, aged 47, was admitted to hospital at 9:00 p.m. on March 20, 1951. She was a short, well built woman, five feet two and a half inches in height, weighing 120 pounds. She was born in Norway. Her family moved to Canada when she was in her teens. She was married in her early twenties and has had three children. Her youngest child, a son, is 22 years old now and happily married. He has one child—a boy of six months.

Mrs. Felsen is interested in many things, cooking and music taking priority. When she was at home she liked nothing better than to try out new recipes on the family. If they liked them she would copy them into her "Favorite Recipes" book. For the past few years, Mrs. Felsen has been unable to take any active part in musical circles. She still loves to attend concerts, listen to symphonies, and see good movies. She attended the Lutheran church which was near her home. She was interested in church affairs and attended the various circles connected with it. Her husband, Lars, was steadily employed as a mechanic and received a fairly good salary. He, like his wife, had an average education, having completed an equivalent to our grade nine.

On admission to the ward, Mrs. Felsen appeared to be a pale, tired and depressed woman. Her diagnosis was twofold—one condition was acute and chronic osteoarthritis, the other was ulcerative colitis. She had a long history of "trouble with her large bowel," having had many attacks of bleeding with mucus present in the stool and dysentery. When these attacks were severe or lasted a long time, she would develop an anemia of the primary type which responded to liver injections and vitamin B, orally or by injection. Liver extract contains those soluble constituents of the liver which increase the number of red blood cells. Vitamin B-complex increased her appetite and did much to increase her muscular strength. An increase in her appetite during these attacks was absolutely necessary because, if no tonic were given, Mrs. Felsen's attitude toward food was one of distaste and sometimes abhorrence. During these attacks she had from 12 to 20 stools a day. She lost weight and became quite depressed.

Ulcerative colitis is one of the more serious diseases that may affect the digestive tract. A disease of the large intestine, it usually begins in the rectum and tends to spread upwards in the colon to the ileocecal valve. It involves not only the mucous membrane but ultimately all of the layers of the intestinal wall. It usually begins between the ages of 20 and 30, and is characterized by remissions and relapses. The symptoms usually begin insidiously with flatulence, indigestion, distress along the course of the colon, and an occasional loose stool. Gradually the frequency of the stools is increased. These stools may contain mucus, blood, and pus. The diarrhea is usually severe with the number of stools varying from 8 to 20 in one day. Defecation is accompanied by distressing cramps which may also occur during and after meals. Mild or severe anemia may result. The patient

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Miss Hartley is a senior student at the Royal Columbian Hospital, New Westminster, B.C.

usually has a poor appetite and loss of weight.

The treatment for ulcerative colitis is often discouraging. Physical and mental rest are essential, as any nervous or emotional strain may precipitate a relapse. The diet for such a patient is bland, low residue, and high caloric, rich in vitamins and minerals. Sedatives are usually given to control pain. The patient is kept warm, quiet, free from worry and emotional strain. Medications containing opium and bismuth may be used to control the diarrhea.

Two or three months prior to admission Mrs. Felsen experienced considerable pain in various joints. At times the pain would be very severe in her right shoulder and at other times in her dorsal lumbar spine. The joints of her knees and ankles also caused her some discomfort. She was placed on various types of therapy at home, such as salicylates, rubefacients, and vitamin B, either orally or by injection. Salicylates are given to help reduce fever, pain, swelling and inflammation. They are of value in controlling painful and disabling symptoms, even though the effects may last only while the medication is continued. The dosage of sodium salicylate is usually 10 to 15 grains given every three to four hours. A rubefacient is a substance which produces a reddening of the skin by dilating the blood vessels. Some substances used are: mustard, camphor, capsicum, oil of turpentine, and resinae. In Mrs. Felsen's case this type of therapy was of no avail. She was feeling miserable, her appetite was poor, and she was in a poor general condition, so she was admitted to hospital for more intensive treatment.

On admission, Mrs. Felsen had pain in her lumbar region, left shoulder and left arm. A slight swelling of the joints of the left hand was apparent. She had had no attacks of ulcerative colitis for several months and the condition seemed to be well under control.

On examination by the doctor her eyes, ears, nose and throat were negative, her chest clear, the heart seemed normal, and her blood pressure was 130/75. Her right shoulder showed some limitation of movement and was painful on pressure, but no nodules were palpable. Her dorsal and lumbar spine were painful when sitting up or when she attempted to bend. She had no limitation of movement in her joints. On rectal examination considerable contraction of the sphincter was present. She was placed on a low residue, high calorie diet. A fracture board was placed on the bed which did a little to ease some of the pain in the lumbar region. Infrared lamp treatments were given to the right shoulder and lumbar region. Vitamin B, 1 cc. intramuscularly, was given every day. Liver injections, 2 cc. intramuscularly, were given every two days. An x-ray of the dorsal spine revealed no lesion but the bones showed a well marked osteoporosis. The vertebrae were slightly narrowed. There was evidence of a lumbosacral subluxation. After 20 days of the above treatment there were no visible signs of improvement so, on March 26, she was considered for cortisone therapy.

Cortisone is produced in the body by the adrenal cortex which depends for stimulation on the activity of the anterior pituitary gland. There are three basic groups of functions associated with the adrenal cortex—an electrolyte controlling mechanism, a protein and carbohydrate metabolism controlling mechanism, and an androgenic mechanism. These functions of the adrenal are partially under the control of the pituitary gland. The adrenal cortex is necessary for the maintenance of life. It is the adrenal gland that allows the body to withstand stresses.

Cortisone, as used in the hospitals, is a synthetic preparation that augments the supply produced by the adrenals. However, if it is used over a long period of time and in excessive amounts the adrenal cortex will atrophy. The exact physiological function of cortisone is not known but it is capable of producing superhuman force in fear or stress. Continued excessive use eventually causes collapse

and death. Cortisone has a selective effect on diseases, aiding in some and not affecting others. It relieves pain, distress, and produces euphoria in varying degrees. Cortisone may increase the blood sugar. There may be a retention of sodium which, in turn, holds fluid in the body. There may be an excessive excretion of potassium. This upsets the electrolyte balance and edema may result. The unusual loss of potassium may cause muscular weakness. A marked lowering of the sedimentation rate from a high figure to normal occurs, also a reduction in the eosinophil count.

Cortisone is given either by intramuscular injection or in tablet form. In giving it intramuscularly it is necessary to use a long needle—one approximately one and a half inches long for deep injection—because the drug is irritating to the tissues. The injection must be made in the gluteal muscle. If given into the fatty tissue an aseptic abscess may result.

There are six tests that should be made before cortisone therapy is commenced. They are: an electrocardiogram, an x-ray of the chest, a complete blood count, a sedimentation rate, a blood sugar, and a serum sodium and potassium analysis.

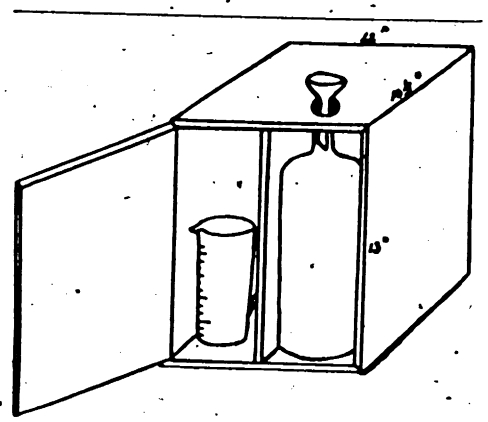
Cortisone prevents the healing of fibrous tissue and also liquefies fibrous tissue, so is definitely contraindicated in a person who has or has had tuberculosis. Although great strides have been made in the treatment of many conditions which previously had responded poorly to therapy by the use of cortisone, it has some undesirable effects. Some of these effects are: excessive euphoria, insomnia, occasional nightmares and depressions, hirsutism, and certain skin changes. The treatment of the more serious of these undesirable effects is sedation and a lessening of the dosage or the discontinuance of the drug altogether.

Mrs. Felsen received the preparatory tests—her sedimentation rate was 60, her electrocardiogram was within normal limits, her chest x-ray was negative, her blood sugar was normal and also her red blood cell count. She commenced cortisone therapy on March 29. Her weight prior to receiving cortisone was 123 pounds. The pain in both shoulders and lumbar region was severe and was relieved little by Frosst 292's. She was very depressed and at times was found crying to herself.

Mrs. Felsen received cortisone 300 mgm. by intramuscular injection the first day, 200 mgm. the second day, and 100 mgm. daily subsequently. After the first day of cortisone administration she felt improved. She experienced less pain and was able to move about more freely without causing severe discomfort. By the third day she was free of pain and wanted to be allowed out of bed.

She was placed on a cortisone diet which was ordered from the diet kitchen. In this diet, salt is restricted and all fluids are measured accurately. Because of her previous history of ulcerative colitis, she was also placed on a bland, low residue, high caloric, high vitamin, and high mineral diet. When she went on the cortisone diet the dietitian sent up a card stating the amount of fluid that would be on her meal tray. The tray was checked after each meal and the number of ounces of fluid consumed were marked down on the intake sheet at the patient's bedside. She had a measured water jug and the amount of water drunk was noted accurately. The total intake was then recorded on the cortisone chart.

An accurate record was kept of the output by placing all voidings in a winchester bottle which was enclosed in a white box and kept under her bed. A diagram of this box is shown, as we have found it a great help in keeping an accurate output record. The winchester was emptied and the urine measured accurately each morning. The total intake and the total output were compared with the daily weight. The weight was taken after voiding in the morning but before breakfast. This comparison was invaluable because it showed whether the patient had voided a satisfactory amount in comparison to the intake. If there was a marked difference in



BEDSIDE BOX FOR SAVING 24-HOUR URINE
Funnel is placed through hole in top of box and urine poured into winchester from graduate. Then graduate and funnel are placed in box and cork is fitted in hole. The box, painted white, is not unsightly and there is no odor. We have found that there are fewer mistakes in measuring output if measurements are made at the bedside instead of in the service room.

this the person charting could note if the patient was putting on too much weight too quickly by checking the weight chart.

The danger of retaining too much fluid is ever-present in a patient receiving cortisone, due to the effect this drug has on the electrolyte balance of the body. If edema results and becomes a problem diuretics may need to be given. Diuretics act on the kidney cells, increasing permeability, and also increasing the circulation to them. If the diuretics do not improve the condition, the dosage of the cortisone has to be lessened or perhaps discontinued altogether. Mrs. Felsen was very fortunate in not being troubled with fluid retention.

On the fourth day Mrs. Felsen was allowed up to the bathroom and was permitted to have a tub bath *ad lib.* The tub bath had a soothing effect on her. She would usually sleep for an hour or two after her bath. Her temperature remained normal and her sedimentation rate, which had been 60 on admission, had dropped to 25 by April 7. She had no attacks of ulcerative colitis while in the hospital and felt much improved. Her hemoglobin on April 16 was 84% (normal range—80-100%).

On April 20, Mrs. Felsen's cortisone injections were replaced by oral tablets. Because she was doing so well on this medication and would soon be ready to go home, the doctor decided to reduce the amount to 75 mgm. daily to see if the pain would return and if so with what degree of severity. Mrs. Felsen was praying that she would be able to manage on the reduced dosage, as the expense of cortisone was hard on the family budget. The first two days of the reduced dosage she experienced some pain in the lumbar region and left shoulder. Frosst 292's were given and the infrared lamp was administered to these areas more frequently. After four days of the reduced therapy she was experiencing only slight discomfort. No further medication for painful joints was needed other than the infrared lamp two or three times daily. On April 28, Mrs. Felsen was discharged with instructions to continue taking cortisone 75 mgm. daily.

Prior to discharge Mrs. Felsen was warned of the importance of watching her weight daily. The doctor placed her on a low salt, low residue, high caloric diet. The dietitian gave her a list of the non-residue and low residue foods in order to aid her in planning proper meals. Even though Mrs. Felsen's general physical condition had improved with the cortisone, the doctor still wished her to continue taking vitamin B before meals. The danger symptoms were explained to her and she was advised to be very observant and watch for any signs of an excess of cortisone. The signs suggested were swelling of the knees, ankles, wrists or legs, and any change in the contour of the face resulting in a moon-faced appearance. She was reminded of the importance of good general skin care and told to report to the doctor immediately if any unnatural growth of hair, increased striations, pronounced acne or other skin conditions occurred.

Mrs. Felsen presented no problem in rehabilitation nor did she require help in re-adapting herself to home life. She had been able to do all her own housework and no specific change in her routine was necessary. The cost of cortisone was a problem which faced her and her husband but, due to the fact that Mr. Felsen was steadily employed, no social assistance would be needed. Mrs. Felsen was a sensible woman so that in the event of any overdosage symptoms occurring she would not hesitate to visit her doctor.

By doing this case study I have gained a greater knowledge of the composition and effect of cortisone on the human body. It has shown me the reasons for the accurate charting of the intake and output of a patient placed on cortisone therapy. The fact that Mrs. Felsen had had ulcerative colitis as well gave me an opportunity to study the treatment, symptoms, and effect of that condition. The noticeable change in her mental attitude after the first few days of cortisone therapy demonstrated another effect that cortisone may have on a patient.

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Book Reviews

Textbook for Health Visitors, by Llywelyn Roberts, M.D., I. G. Davies, M.D., and Beryl D. Corner, M.D. 551 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $4.00

Reviewed by Marion C. Story, Public Health Nurse, Alta. Dept. of Public Health, Medicine Hat.

The preface states that the health visitor is one of the oldest of social workers. She is now described as one who, in association with the general practitioner and local health authority, has become the adviser in preventive medicine and health teacher to the family unit. She is recognized as a statutory officer under the National Health Service Act in Britain.

This textbook is written specifically for the student health visitors studying for their certificate. The authors also anticipate that it will be an authoritative manual for qualified health visitors, district nurses, and others engaged in medico-social work.

A good portion of the material covers such topics as Central and Local Government, National Health Service Act, Social Legislation, Child and Maternal Care, Delinquency, etc., all of which would make it a valuable reference book for all those engaged in the medico-social field in Great Britain. However, from a Canadian public health nurse's point of view and regarding the health visitor as a medico-social worker, one would consider that the authors have gone into too much detail on such subjects as anatomy and physiology of the female reproductive system, fetal circulation, and the central nervous system, and also on infant feeding, management of labor, and pre- and post-natal care. Without such detail more stress could have been placed on sociology, psychology, preventive medicine, counselling, and other subjects pertaining to medico-social welfare.

There are some rather dogmatic statements to which exception might be taken—for instance, in the paragraph on mental deficiency psychiatrists would question the statement—"Failure to walk by the age of two years, provided there is no abnormality of bones, joints, and muscles, is always due to mental defect."

This would be a good reference book, particularly for those interested in or studying the recent social legislation in the United Kingdom but could not be recommended as a text for schools of nursing in this country.

Plastic Surgery—An Introduction for Nurses, by C. R. McLaughlin, M.B. 125 pages. British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1951. Price $2.50.

Reviewed by Mary E. Pickens, Supervisor of Nurses, Civic Hospital, Peterborough, Ont.

This book is new. No book of a similar kind has been available from which to borrow ideas, therefore this effort is original. Its purpose is to present plastic surgery to the nurse who is interested in its problems or involved in its practice.

The subject matter covers many topics vital to students and teaching faculty. It is of particular interest to senior students.

The text is divided into definite units. The historical perspective of plastic surgery is most enlightening and makes us again realize that this is really an old subject brought up to date.

The special emphasis, with illustrations, on the many different types of skin grafts are of great value as teaching aids.

The author's discussion of lip or palate defects is very clear and concise. The preparative and post-operative care of these patients is very clear and gives the nurse good basic principles from which to study the individual needs of this type of patient.

This book is written in simple language and at the same time covers much detail. Every school of nursing library should have a copy for reference purposes.

Having Your Baby—Modern Instructions for Expectant Mothers, by Leonard H. Biskind, M.D. 169 pages. Random House of Canada Ltd., 1149 King St. W., Toronto 3. 2nd Ed., revised. 1951. Price $2.25.

Reviewed by G. M. Watt, Nursing Counsellor, Civil Service Health Division, Dept. of National Health & Welfare, Ottawa.

The general purpose of the modern prenatal instructions contained in this book is to give a thorough understanding of what pregnancy entails. In the author's words, "An attempt has been made to remove the veil of mystery from pregnancy and childbirth, with the hope that, by so doing, patients will cooperate more fully with their physicians. This will permit both patients and physicians to strive for a common goal—namely, alleviation of anxiety during pregnancy and improvement in maternal care."

The information regarding each aspect of pregnancy is arranged in a concisely numbered point system. This makes the material easily accessible and assimilable. The author deals carefully with each phase, including preconceptional care, prenatal, delivery, and continuing postpartum care for the mother, and post-natal care for the infant. The completeness of detail makes this book a valuable tool for any nurse.

The objective way in which Dr. Biskind deals with abnormalities—e.g., tubal pregnancy—makes it a safe and valuable book to put in the hands of the mother herself. He presents, with clarity and authority, the answers to the questions uppermost in the mind of the expectant mother. The physician could recommend this book to his patients and save himself many hours of discussion.

The revised chapters on diet and vitamins, written by the author's brother, Dr. Morton S. Biskind, embody the very latest accepted thinking on these subjects in relation to pregnancy.

A glossary defines all of the medical terms that may be unfamiliar to the reader.

Pediatric Allergy, by Robert Chobot, M.D. 284 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 1951. Price $6.10.

Reviewed by Elizabeth Walther, Head Nurse, Pediatrics, St. Joseph's Hospital, Victoria, B.C.

The author, who is one of the acknowledged authorities in this field of medicine, attempts to show the pediatrician and general practitioner how to diagnose and treat allergy in children with a greater degree of success.

The opening chapters deal with descriptions of the many forms of hypersensitivity and diagnostic procedures. In these chapters the importance of complete history taking, the approach to the allergic child, and the various tests is stressed.

In the following chapters, the author proceeds to enlarge on the many types of allergies in children. Included among these are asthma, food allergy, vasomotor rhinitis, hay fever, skin and eye allergies, as well as chapters on serum and drug allergy, migraine and physical allergy. The basic facts are set forth in simple straightforward language and deal with the main clinical aspects of diagnosis and treatment.

In the last chapter he makes the following statement: "The great hope of allergy in the light of our present knowledge depends

on the development of better standardization of extracts and a better understanding of the basic pathologic changes and their mechanism."

All through the author has endeavored to present both sides of each argument and has in his own words "supplemented this with his own opinion and practice."

The book is interesting and would be of value as a reference book in any school of nursing library.

Principles of Microbiology, by Charles F. Carter, B.S., M.D. 514 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1951. Price $5.25.

Reviewed by Josephine S. Betz, Instructor of Nurses, Highland View Hospital, Amherst, N.S.

The author's purpose is not to add to existing knowledge of microbes but to present to the student a brief general survey of the principles of the most important disease-producing microbes and a discussion of the reaction of the animal body to contact with them. The author has also pointed out the activities of microbes, which are of greater importance to man than the diseases which they bring about. By this, he means the part that microbes play in the processes of nature, in industry, and in the diseases of plants which they cause.

We do not stress enough the work of useful bacteria. We usually think of their harmful aspect. "Many of the vitamins essential to animal and human nutrition are formed in the large intestine by its microbial inhabitants." "Bacteria also build up certain proteins and fats necessary for metabolism."

The chapters on Commercial Uses of Bacteria, Description of Microscope, and Diseases Caused by Viruses are helpful but the student does not need as much detailed knowledge as is included in the chapter on Medical Parasitology.

It is a book that can be recommended as a text for student nurses.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Amherst, N.S.: *Rose Marie Brine* (Victoria Gen. Hosp., Halifax). Brantford, Ont.: *Nancy Giancola* (St. Joseph's Hosp., Hamilton). Cornwall: *Mrs. Catharine Arthur* (New Waterford Gen. Hosp., N.S.). Edmonton: *Mrs. Alma Edwards* (Winnipeg Gen. Hosp.). Gravenhurst, Ont.: *Jessie Yule* (Toronto Gen. Hosp. and University of Toronto) as nurse in charge. Hamilton: *Helen Mackay* (T.G.H. and McGill University) as district superintendent. Kingston: *Muriel Read* (Montreal Gen. Hosp.). Lachine, Que.: *Germaine D'Allaire* (Ste. Justine Hospital, Montreal, and University of Montreal) and *Cecile Vincent* (Notre Dame Hospital, Montreal, and U. of M.). Liverpool, N.S.: *Shirley Mills* (Payzant Memorial Hosp., Windsor, N.S.). Medicine Hat, Alta.: *Beulah Rose* (University of Alta. School of Nursing). Moncton, N.B.: *Katherine Daigle* (Hotel-Dieu, Moncton). Ottawa: *Mrs. Marion Dewar* (St. Joseph's Hosp., Kingston) and *Ruth Gorssline* (Montreal Gen. Hosp.). Porcupine, Ont.: *Jean Cummine* (T.G.H. and U. of T.) as nurse in charge. Sherbrooke: *Marie Berthe Maille* (Hotel-Dieu, Sherbrooke). Smiths Falls, Ont.: *Lois Leeson* (Victoria Hosp., London, and U. of T.) as nurse in charge. Surrey, B.C.: *Sophie* and *Thorun Armgrimson* (Winnipeg Gen. Hosp.). Toronto: *Irene Boake* (Vancouver Gen. Hosp.), *Mrs. Eleanor Brown* (Toronto East Gen. Hosp.), *Olive Cruickshank* (V.H., London, and McGill U.), *Marie Joyce* (Wellesley Hosp., Toronto, and U. of T.), *Alexandra Krewesky, Katherine Stevenson* (Toronto Western Hosp. and U. of T.), and *Joy Walling* (T.G.H. and U. of T.). Vancouver: *Roberta Greig* (Royal Jubilee Hosp., Victoria, and University of British Columbia), *Norma Jamieson* (V.G.H.), and *Edith Linney* (B.Sc., University of Alberta). North Vancouver: *Ruth Garnham* (Grace Hosp., Windsor, Ont.) and *Mrs. Dorothy Sharp* (R.J.H., Victoria). Winnipeg: *Catherine Cosgrove* and *Margaret Woods* (W.G.H.). York Township, Ont.: *Dorothy Mizuhara* (V.G.H. and McGill U.).

Reappointments—Ottawa: *Mrs. Mary Hoare* and *Margaret Sanderson*. Saint John, N.B.: *Mrs. Charlotte Duncan*. Toronto: *Mrs. Barbara Gow*.

Transfers—*Anna Charles* from Gravenhurst as nurse in charge to North York, Ont., staff; *Betty Cox* from Ottawa to Guelph as nurse in charge; *Kay Fleming* from Oshawa to Montreal; *Beryle Hawley* from Port Col-

borne, Ont., as nurse in charge to Montreal staff; *Marion Hellyer* from Orillia, Ont., as nurse in charge to Surrey staff; *Valda Howard* from Lindsay, Ont., as nurse in charge to Timmins, Ont., as nurse in charge; *Helen King* from Smiths Falls as nurse in charge to Truro, N.S., as nurse in charge; *Harriet McGeary* from Belleville as nurse in charge to Peterborough as nurse in charge; *Mary McLean* from Saskatoon as nurse in charge to Lincoln County, Ont., as nurse in charge; *Helen Nelles* from Hamilton to Lindsay as nurse in charge; *Merle Pringle* from Winnipeg to Fort William as nurse in charge; *Dorothy Sisson* from Fort William as nurse in charge to Saskatoon as nurse in charge; *Beatrice Tomlin* from Waterloo, Ont., to Brampton, Ont., as nurse in charge.

Leave of Absence—Hamilton: *Janet Wolverton.*

Resignations—Cornwall: *Mrs. Ruth Martin.* Edmonton: *Mrs. Thelma Irvine.* Hamilton: *Helene Snedden* as district superintendent; *Lorna Warman.* Kingston: *Mrs. Marion McNevin.* Lachine: *Norma Davis.* Lincoln County: *Amy Parliament.* Liverpool: *Nellie Beaton.* Moncton: *Mabel Shaw.* Montreal: *Claire Cadieux, Mrs. Cratty Carageorgiou, Mrs. Theresa Clark, Mrs. Myrtle Greene, Julie LeBlanc,* and *Elizabeth McPhedran.* Ottawa: *Mrs. Francis Brown, Bessie Buck,* and *Mrs. Eileen Chatwin.* Peterborough: *Mrs. Evelyn Fitzsimmons.* Porcupine: *Liv-Ellen Lockeberg* as nurse in charge. Regina: *Marion McEachran.* Sherbrooke: *Mrs. Kay Baker* and *Olivette Roy.* Surrey: *Mrs. Joy Stewart.* Toronto: *Mrs. Constance Arnold, Mrs. Kathleen Beacock, Mrs. Cicely Hall, Irene Jackson, Grace Rogers,* and *Florence Sinclair.* Vancouver: *Lillian Wooding.* North Vancouver: *Verna Moore* and *Frances Turnbull.* West Vancouver: *Thelma Johnston.* Windsor, Ont.: *Barbara Culham, Mrs. Ruth Thompson,* and *Barbara Trimble.* Winnipeg: *Irene Allsen.*

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Dorothy Adams* (Winnipeg Gen. Hosp.; University of Toronto general course; McGill University administration and supervision course), formerly with Oxford County health unit, to Neebing Township board of health; *Mary (Churchill) Connell* (Calgary Gen. Hosp. and U. of T. gen. course) and *Laura (Shaver) Nolan* (Toronto Western Hosp. and U. of T. gen. course) to East York-Leaside health unit; *Jean (Macfie) Cook* (Soldiers' Memorial Hosp., Orillia, and U. of T. gen. course), formerly with Peel Co. health unit, to Simcoe Co. health unit; *Helen Etherington* (St. Catharines Gen. Hosp., U. of T. gen. course, and advanced course in admin. and supervision), formerly public health nursing supervisor, Muskoka district health unit, to Hamilton board of health; *Mildred (Laughlin) Fox* (Belleville Gen. Hosp. and U. of T. gen. course) to Belleville board of health; *Marion Jamieson* (Brantford Gen. Hosp. and University of Western Ontario certificate course) and *Barbara Stuart* (Hosp. for Sick Children, Toronto, and U. of T. gen. course) to Guelph board of health; *Ernestine Robidoux* (Ottawa Civic Hosp. and McGill U. public health nursing course) to Peel Co. health unit; *Thelma Ross* (St. Joseph's Hosp., Port Arthur, and University of Manitoba p.h.n. course) to Port Arthur board of health; *Shirley St. Pierre* (St. Michael's Hosp., Toronto, and U.W.O. cert. course) to Windsor board of health; *Margaret Shoebottom* (Victoria Hosp., London, and U. of T. gen. course) to Huron Co. health unit; *Ellen Turpin* (health visitor) to Scarborough Township board of health; *Phyllis Wingrove* (Hamilton Gen. Hosp. and U. of T. gen. course) to Kitchener board of health.

Resignations: *Mary Lake* from Kent Co. health unit, *Margaret (Leonard) McEachren* from Brant Co. health unit; *Grace Walker* from York Co. health unit; *Mrs. Bessie Watt* from Belleville board of health.

The Rule

Do all the good you can
By all the means you can
In all the ways you can
In all the places you can

At all the times you can
To all the people you can
As long as ever you can.

—JOHN WESLEY

News Notes

ALBERTA

CALGARY

A meeting of District 3 was held in November when several motions were carried with regard to the Civil Defence Atomic Nursing course which was being held in Edmonton. Mrs. C. White has been appointed to the Council for Social Agencies. Mr. Kay from Coste House spoke on the initiation, aims, and activities of the Allied Arts Group.

GRANUM

Nurses from Macleod, Granum, and Claresholm met at the home of Mrs. W. Henker to organize a chapter of nurses for civil defence. Delegates will be appointed to attend provincial meetings and bring back a report of any plans. The following officers were elected: President, Mrs. F. Watkins, Claresholm; vice-president, Mrs. R. Hilliard, Macleod; secretary-treasurer, J. Hermans, Claresholm.

JASPER

It was reported that 1,095 persons attended the free chest x-ray clinic which the Edith Cavell Chapter sponsored here. A letter of thanks was received from Dr. Davison for the efforts of the chapter. Due to the scarlet fever scare in Jasper, Dr. O'Hagan asked the chapter to assist him in a mass inoculation program when 250 children received this service. A motion was carried, asking Dr. O'Hagan to consult the sanitary inspector regarding stricter enforcement of public health regulations. It was suggested that a résumé of the public health set-up be presented to the Home and School Association in an effort to stimulate public opinion.

RED DEER

A successful tea and raffle was held last summer by the district. The proceeds will go toward the furnishing of a ward in the new wing of the Municipal Hospital. Twenty-five dollars was donated to the Jamaican Relief Fund.

BRITISH COLUMBIA

CLOVERDALE

At the annual meeting of South Fraser Valley Chapter the following officers were elected: President, Mrs. G. O. Hughes, Langley Prairie; vice-presidents, Mrs. D. Crane, Langley Prairie, and K. Ross, Cloverdale. Committees: Program, F. Vernon, Langley Prairie; publicity, Mrs. H. Grieve, New Westminster; membership, Mrs. D. Stewart, New Westminster.

CRESTON

S. Davidson has resigned as matron of the Creston Valley Hospital. It is reported that Miss Davidson will superintend a training school. Because of the shortage of nurses, only emergency operations will be carried out until the hospital staff is again at full strength.

CUMBERLAND

The Plateau Chapter were hostesses at a meeting of Vancouver Island District held in October. The guest speaker was Dr. C. A. Jamison of Alberni, whose topic was "Congenital and Other Deformities of Children."

DUNCAN

Fifteen members were present at the first meeting of Cowichan-Newcastle Chapter when Mrs. M. Langlois presided. Nurses were in attendance from Duncan, Chemainus, and Ladysmith. Because of the revived activity in each town, the question of returning to the smaller chapters was discussed. It was pointed out, however, that these groups are made up of inactive nurses (not eligible to hold office in a chapter) and that they still prefer the business to be carried out in the combined group. It was found necessary to have all the executive in one town. The quarterly meetings will be carried on for another year.

Mrs. N. (Fairbanks) MacPherson and G. Farquharson, of the Duncan public health staff, showed the film "Meeting the Emotional Needs of the Child."

LADYSMITH

Mrs. J. W. Neville was elected president of the Graduate Nurses' Social Club at a regular meeting when 14 members were present. Mrs. P. Gannon is secretary-treasurer; Mrs. H. Steele, social convener. Mrs. Neville succeeds Mrs. T. Brown. Theme of the program for the coming months will be both educational and social with speakers drawn chiefly from local sources. M. Leggett, matron, is slated to give an account of the B.C. hospital convention which she attended as a delegate. It was decided to use the funds realized from the Nightingale Tea to purchase a new surgical dressing carriage.

Best wishes and a small gift were extended to the retiring secretary, Mrs. H. McKenzie, who will reside in Victoria. Mrs. E. Gregson won the penny raffle.

PRINCE GEORGE

Care and treatment of different types of mental sickness in British Columbia was one of the aspects of the subject discussed by Dr. H. T. Lowe of Cariboo Health Unit at a meeting of Fort George Chapter. Dr. Lowe, who was formerly on the staff of the Provincial Mental Hospital, Essondale, gave an enlightening address on "Mental Illness."

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1951 Index

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Chapter members have also attended lectures given by Ferne Trout, R.N.A.B.C. itinerant instructor, on "Nursing Aspects of Atomic, Biological and Chemical Warfare."

REVELSTOKE

At a meeting of the local chapter plans were made for an Amateur Hour which would be recorded at time of presentation for future rebroadcast from Kelowna. The chapter hopes to raise sufficient money to start a fund to provide for nurses to special patients requiring constant attention if they are unable to pay for these services themselves. Any additional sum will be used as a bursary for any girl wishing to enter nurses' training and requiring financial aid.

Mrs. E. Gable gave a report on the R.N.-A.B.C. annual meeting which she attended as delegate. E. Rutherford was appointed president to complete the term of the past president, Mrs. L. DeBlass. Mrs. DeBlass was extended a vote of gratitude for her inspiring leadership during the difficult days of organization.

Three new members were welcomed to the chapter—B. Hazelwood, B. Gibbs, and D. Widifield.

VANCOUVER

A three-day Professional Nurses' Exposition, sponsored by the General Hospital Alumnae Association, was held in October. Emphasis was placed on recent medical and nursing advances in such fields as premature infant care, poliomyelitis, head injuries, and surgery. Students, graduates, and retired nurses were among the 300 who registered for this exposition. The following V.G.H. staff nurses participated in the program: H. Saunders, clinical instructor in O.R. technique; C. Bing, head nurse, nursing care of patient with head injuries; Mrs. E. Wilders, pediatric supervisor, lecture and demonstration. Films were also shown.

Co-conveners of the "PNE" were M. Fullerton and Miss Bing.

MANITOBA

WINNIPEG

General Hospital

"Going—Going—Gone!" was the theme of an alumnae meeting held in November when an auction sale followed the business meeting. Fun was had by all as the bidding rose to enthusiastic heights. A satisfactory amount was realized.

The annual tea is scheduled for February 2 when various professional men will be the honored pourers.

A round-faced, 34-year-old Dutchman is creating a precedent at the hospital. Bowe (Bob) Bosma is the first male nurse ever attached to the hospital staff. He is an operating room nurse. Bertha Pullen, superintendent of nurses, along with Dr. H. Coppinger, hospital superintendent, is "pioneering" a school for male nurses in the city. The three-year course will include care of paraplegics, orthopedic conditions, and stints at Brandon Mental Hospital and hospital out-patient departments.

Misericordia Hospital

At a meeting of the alumnae association the announcement that a new nurses' home will be built was greeted with great enthusiasm. Plans for obtaining a suitable site for the new building are near completion and it is hoped that construction will begin in the spring.

Sr. St. Odilon has arrived from Milwaukee to direct the School of Nursing. A graduate of Joliette University, Chicago, and of Marquette University, Milwaukee, she brings a wealth of knowledge and experience to the school. M. Wilson, who has completed a post-graduate course in teaching at McGill School for Graduate Nurses, is clinical instructor. Mary (Vacjener) Gingaris has resigned from the operating room staff. R. Steiner and Jean Brewer have also left the O.R., the former to do special duty, the latter to become matron of the hospital at Atikokan, Ont. New additions to the O.R. include D. Borthistle and L. Kubesh. S. Bennett, P. Cormylo, and D. Gardiner have also joined the staff.

NEW BRUNSWICK

MONCTON

Linda Russell was elected president of Moncton Chapter at the annual meeting. Other officers include: Vice-presidents, Mrs. N. Smith, M. Downing; secretary, S. MacLeod; treasurer, Mrs. M. Wilbur. Section conveners: Institutional nursing, F. Breau; private nursing, M. Downing; public health nursing, R. MacKenzie. Committee conveners: Public relations, Mrs. D. Van Buskirk; ways and means, L. Good; refreshments and program, Misses Elliott, Tait, Hanusiak, Rossignol; membership, Mrs. E. Howard; flowers, A. Alexander. Representatives to: Press, Mrs. M. Robinson; *The Canadian Nurse*, J. Weston; Local Council of Women, M. Kay.

Mrs. M. J. Perry, chairman, conducted the appointing of a new slate of officers for the Registry Board, which was as follows: Chairman, Mrs. Perry; secretary, S. MacLeod; treasurer, Miss Richardson. Representatives from: Moncton Hospital, F. Breau; Hotel-Dieu, A. Allain; private nursing section, Mrs. J. Pettet, M. Downing.

Mrs. M. Shaw and M. Kay were named conveners for the table-setting contest sponsored by Fort Moncton Chapter, I.O.D.E.

Reports of the 35th annual meeting of the N.B.A.R.N. highlighted a regular meeting of the chapter. Nurses attending from this centre were: F. Breau, K. Richard, representing Moncton Hospital; J. Weston, chapter delegate; Mmes F. Northrup and I. MacKenzie, Tuberculosis Hospital; E. Warman, M. Carroll, G. Belleisle, and E. Rossignol, public health; Mrs. D. Van Buskirk, Swift Canadian Co. Ltd.

NOVA SCOTIA

NEW GLASGOW

Aberdeen Hospital

Mrs. H. A. Locke entertained the alumnae association at a well attended meeting when it was decided to donate a sum of money to the Local Council of Women to assist in paying the expenses of nurses taking the ABC Warfare Nursing Course in Halifax. A committee was appointed to make plans for the annual banquet. It was decided to remember a friend in England with a food parcel for Christmas. The Pantry Sale was also discussed. Mrs. Locke, assisted by the lunch committee—M. Muirhead, Mmes D. MacLean, W. Forbes, and V. MacDonald—served refreshments.

ONTARIO

DISTRICT 1

Dr. J. F. Roberts was guest speaker at a meeting of District 1, held in Sarnia, when his subject was "Recent Advances in Surgery." Nurses from all parts of Western Ontario were in attendance.

CHATHAM

Public General Hospital

Last October, 17 past presidents of the alumnae association, one of whom is now serving as a missionary in China, were recipients of many verbal bouquets and a past president's pin at the 30th anniversary dinner held at the William Pitt Hotel. Over a hundred guests were present.

Sharing the spotlight with the past presidents were George Parry, M.P., the speaker of the evening, and Priscilla Campbell, hospital superintendent, who introduced and presented the past presidents' pins. Miss Campbell, alumnae honorary president, was presented with a silver tray by Mrs. A. Howe, alumnae past president.

Other past presidents attending were Annie Head, Jessie Tinney, Dorothy Thomas, Mrs. Alma Longeway of Windsor, Lillian Hastings, Deby Hooper, Mrs. H. Goldrick, Mrs. J. W. Cripps, Mrs. A. E. Harrison, and Mrs. W. Booth. Absent were Blanche Pardo, missionary in China; Mrs. T. Smith; Mrs. J. Bales, West Lorne; Mrs. C. Coyle, Montreal; Mrs. G. Jennings, Sarnia; Mrs. W. Herbert, London.

LONDON

An educational program, dealing with many phases of nursing, was arranged by the Community Nursing Registry. Lecturers included Drs. W. T. Haslett, B. L. Hession, D. W. B. Johnston, W. Hardman, J. C. Kennedy, and C. F. S. Fisher. R. M. Rouatt, registrar, was in charge of enrolment.

DISTRICTS 2 AND 3

KITCHENER

Two hundred and twenty-three members of Districts 2 and 3 met in October for their final gathering before the districts were divided into two distinct bodies. The nurses represented 10 counties between Owen Sound and Simcoe—Brant, Oxford, Perth, Huron, and Norfolk in District 2; and Bruce, Grey, Dufferin, Wellington, and Waterloo in District 3.

District 2 has 288 members with 14 associate members. District 3, though the new group, has 454 members with 14 associate members. The resolution for division was sent to the Board of Directors meeting in Brantford last May and ratification was given.

The executive for District 2 is as follows: Chairman, Mrs. J. Sanders; vice-chairmen, M. Snider, M. Holland; secretary-treasurer, M. Patterson. Committee representatives include: O. Plumstead, N. Cunningham, T. Dawson, and Mrs. V. Byrick. Councillors: Brant, N. E. Neff; Huron, M. Love; Norfolk, R. E. Misner; Oxford, N. Hicks; Perth, M. J. Brydon. Executive for District 3 includes: Chairman, W. Cooke; vice-chairmen, C. Adams, L. Campbell; secretary-treasurer, M. Cruickshank. Committee representatives include: Sr. St. Edmund, M. Lapsley, H. Fasken, N. Boyle. Councillors: Bruce, E. M. Schaab; Dufferin, M. Marshallmeade; Grey, I. Weirs; Waterloo, A. Psutka; Wellington, M. Thompson. A. Bingeman was convener of the nominating committee, assisted by A. Ballantyne and F. Clarke.

Mrs. J. Sanders, director of nursing, Ontario Hospital, Woodstock, was chairman of the meeting. D. Hartsell of the Kitchener-Waterloo Hospital was soloist while installation of officers was done by G. Sharpe, director of nursing, Western Hospital, Toronto, and R.N.A.O. president. Following the afternoon sessions a tour of the Kitchener-Waterloo Hospital preceded a dinner party. The guest speaker was Mrs. C. W. Cryderman of London.

Additional speakers at this division meeting were Dr. L. V. Lang, past president, Kitchener-Waterloo Academy of Medicine, and Dr. A. J. McGanity, medical adviser of civil defence for Waterloo County, who spoke briefly on the value of preparedness in the event of atom bomb warfare. Miss Sharpe also spoke on this topic. W. Cooke, director of nursing, General and Marine Hospital, Owen Sound, reported on the refresher course held at the University of Toronto School of Nursing.

BRANTFORD

At a meeting of the Brantford General Hospital Alumnae Association there were two guest speakers, both alumnae members. Grace Anderson told of her experience while nursing in Fresno, California. This city, situated in the centre of the state, is extremely hot and dry in the summer months and is in the heart of the fruit and cotton growing area. Miss Anderson worked in a "county" hospital, one in which indigent and emergency cases were treated. Most of the patients spoke Spanish. Due to the rapid turnover of patients on the ward on which she worked (acute surgical) and the great shortage of nurses, Miss Anderson found that the nursing became rather impersonal—each of the 35 men resolving into mere numbers as they reached the ward.

The second speaker, Eleanor Coure, showed many colored slides of Bermuda, telling the members about that beautiful colony. Miss Coure was employed at the King Edward VII Memorial Hospital there.

FERGUS

A graduate of the old Grace Hospital, Toronto, Mrs. Adeline Painter, for six years on the staff of Groves Memorial Hospital, has been appointed superintendent of that institution. Previously assistant superintendent, she succeeds Jeanne Cunningham who resigned to be married.

LISTOWEL

Donation of draw curtains and rods for two semi-private rooms at Memorial Hospital was announced at a meeting of the local Graduate Nurses' Association. Mrs. D. Trench, vice-president, was in charge in the absence of Mrs. R. Harrison, president. Mrs. M. Johnston reported on sales of tickets for the carved horse. Discussion was carried on regarding a proposed dance. Mrs. L. Coghlin, Blue Cross convener, told the members of an advance in rates. Lunch was served by Mmes H. Horne and Cross.

ST. MARYS

A regular meeting of St. Marys Graduate Nurses' Association was held at the home of Mrs. D. Patterson, Relton. Mrs. Dicks, president, presided over the 23 nurses in attendance. Mrs. Savage gave the Hospital Auxiliary meeting report. Mmes Arthur, Cushman, Jewell, Murphy, and Dunsford were appointed to make plans for a forthcoming birthday party. Mrs. Martin was in charge of the program and introduced G. Atwell who rendered two solos. Mrs. Ball, guest speaker, chose as her topic "My Experiences in a Hospital." Mmes Patterson, Glass, Hutton, and Ready helped the hostess serve refreshments.

SIMCOE

General business was discussed at a meeting of the Registered Nurses' Association of

Norfolk General Hospital. The year's activities were reviewed and the secretary-treasurer, H. Courtney, presented a satisfactory financial report. The election of officers resulted as follows: President, M. Cheetham; vice-president, Mrs. A. Sheir, secretary-treasurer, H. Courtney; social and entertainment, B. Clarke; publicity and flower fund, Mrs. M. Noble. It was decided to hold only three meetings a year. Mrs. D. Wentzell was the winner of the draw. Refreshments were served by Miss Cheetham.

STRATFORD

New rates for nursing service were outlined at a special meeting of the Board of Directors of the Community Nursing Registry. The rate for eight-hour duty by registered nurses has now been raised to $8.00. The fee for nursing assistant was set at $5.00 per day for eight-hour duty with an additional 50 cents an hour up to 12 hours.

An educational program was held by the registry in October when the following speakers were included as lecturers: Dr. A. N. Eddington, radiologist, General Hospital—X-Ray Examination and the Nurse; Dr. B. A. Campbell—Care of Fractures and Abdominal Surgery. E. Doupe was convener of arrangements, assisted by V. Dunsmore and I. Murray.

A large representation of nurses from the General Hospital attended the annual Florence Nightingale service held at the Church of St. John Evangelist, Elora, in October. The service included the repeating of the Nightingale Pledge by the nurses present. The Rev. James D. Tilly delivered the sermon whose main theme was "The Privilege of Service."

DISTRICT 4

OAKVILLE

Lillian Parsons has been appointed superintendent of Oakville-Trafalgar Memorial Hospital. She had been appointed acting superintendent following the resignation of Florence Roach. A graduate of St. Joseph's Hospital, London, she joined the staff of the temporary hospital three years ago.

Three final-year students at McMaster University School of Nursing will receive four weeks' practical training at the hospital.

ST. CATHARINES

Local nurses were represented at a meeting of the annual Institute for Registry Personnel held in Hamilton when the role of nurses in civil defence was discussed. Among those attending from this area was J. Turner, president of the Graduate Nurses' Association. Speaking before the annual meeting of the Institute, Helen McArthur, C.N.A. president, said that specially trained crews will spread across Canada to instruct in specialized methods for civil defence in a community. The St. Catharines nurses will play an important role under the hospital organization for civil defence which is now being organized. The Lincoln County Medical Association

has taken on the responsibility of organizing the medical branch of civil defence. Nurses will be needed in large numbers for the expanded demands of emergency hospitals for which the staffs are now being planned.

DISTRICT 5

TORONTO

St. Michael's Hospital

V. Murphy was chairman of the committee arranging a bridge and euchre sponsored by the alumnae association. Other committee members included: G. Coyle, M. Hughes, K. Neader, L. McGurk, E. Crocker, M. Brown, Mmes T. Ralston, D. Cochran, J. Dunbar, and J. T. McCormack.

At a recent alumnae meeting G. Murphy stated that there were 332 students in the school of nursing. D. Murphy succeeds P. O'Connor as vice-president; the latter is taking a course in clinical supervision at the University of Western Ontario. Miss Schwanbeck reported on the graduation dance.

The following members are attending university as follows: University of Toronto, Srs. St. Hugh, Margaret Ann; A. Brophy, L. Finlayson, M. Hansen, J. Hefferman, R. Helpert, F. Lummiss, A. Melvanin, V. Murphy, E. O'Neil, M. Paul, H. Pinzhoffer, L. Ryan, H. Smythe, L. Tracey; St. Louis, E. Colgan, M. McGarrell, M. Sullivan, L. Wohler; Queen's, M. Carty; Alma College, Mich., C. Greco. A. McMillan has received her B.A. at University of Toronto.

K. Gies gave a paper at a refresher course for industrial nurses held at McMaster University. S. St. Pierre is with the Windsor board of health. N. Corrigan is doing industrial nursing with the Chrysler Corp., Detroit. A. M. Quigley and M. Shaver are with the York Co. public health unit. E. Murphy is with the Ontario Society for Crippled Children, Hamilton. Sr. Albertine has been transferred from St. Joseph's Hospital, Winnipeg, and is now in charge of the O.R. at St. Michael's. Sr. M. Vianney has been appointed assistant to Sr. Jeanette who is Sr. Superior of St. Joseph's, Winnipeg. Sr. St. Nilus is also on the staff there. Sr. St. Albert has been transferred to St. Joseph's, Toronto, while Sr. Angeline has been appointed to the O.R. there. Sr. Marion is now the superintendent of nurses at St. Joseph's. Srs. Bridget Ann and Eileen have been appointed to St. Michael's. O. Gloster is with the London Clinic. J. Morrison is superintendent of Haliburton Outpost Hospital. T. Clements is with the Queen Elizabeth Hospital, Montreal. C. Young, C. Lee, J. Wittman, and M. Lucey are with the Ann Arbor Hospital. B. Evans is at the Sudbury General Hospital. M. Moher is on the staff of St. Joseph's Hospital, Santa Ana, Calif. E. Greenwood is at Strathroy Hospital.

B. K. Webster is pediatric nursing supervisor and assistant professor of nursing education, University of Michigan. R. Robertson is at St. Joseph's, Victoria. F. McKinnon, R. O'Gorman, and M. Richards are at Cobalt Hospital. R. Burke, V. Haddad, and B. Robertson are at Timiskaming Hospital. C. Hennessey and J. Sutherland are at the Red Cross outpost in Wawa. A. McCabe has left the staff of Catholic Welfare to take the position of health supervisor at St. Joseph's, Toronto. G. Giaschi is stewardess on flights between Vancouver and Victoria. E. I. Burns is serving with a mobile army surgical hospital in Korea.

DISTRICT 6

PETERBOROUGH

H. McGeary, chairman, presided at the annual meeting of the district when it was reported that a membership drive would be held at the beginning of 1952 since the 340 active members and 22 associates in the district is a decrease of 28 from the 1950 total. Members were urged to subscribe to *The Canadian Nurse* and to continue the drive for advertisers in local areas. Chapters were asked to combine on their orders for linen which they are sending to the Queen's Institute Nurses of Britain. Miss McGeary outlined briefly the re-organization which is taking place in the association since the passage of the Nurses' Act. Where formerly there were in each chapter interest groups on public, private, institutional, and industrial nursing, there will henceforth be representatives to the R.N.A.O. and all nurses will meet together in the chapter.

The following officers will serve during the coming months: Chairman, H. McGeary;

vice-chairmen, H. Derry, R. Cunningham, Mrs. M. Pringle; secretary-treasurer, Mrs. J. Patterson. Additional executive members include: M. Mills, M. Greer, G. Clark, C. Droppo, M. Sheppard, Mmes S. Prentice, E. Nattress, H. Roy.

Helen G. McArthur, C.N.A. president, was the guest speaker at the annual dinner meeting of the district when 121 members and 15 student nurses attended. In her address Miss McArthur commented on the course she had taken in the U.S. on ABC warfare, the I.C.N. Board of Directors' meeting she had attended in Belgium, and her travels through other European countries as director of nursing services for the Canadian Red Cross. Miss McArthur was introduced by Mrs. E. Brackenridge, convener, C.N.A. Private Nursing Committee, and thanked by D. Potts, director of nursing, Belleville General Hospital. A gift from the district nurses was presented on their behalf by Mrs. M. B. Pringle.

C. Wilson was acting chairman for the hostess Chapter C, 40 members attending from Chapter A, with headquarters at Belleville, and a number from Chapter B in Cobourg. Nurses were also present from Lindsay and Bancroft being members of Chapter C. A special welcome was given the student nurses from St. Joseph's, Civic, Belleville General, and Lindsay hospitals as this was the first time they had attended an R.N.A.O. district meeting.

An invitation to Belleville for the semi-annual meeting next spring was extended by Miss Potts.

District 9

New Liskeard

Mrs. S. Mallett's home was the scene of a meeting of the Graduate Nurses' Association when 29 members were present. The acting secretary, Mrs. McLean, read the minutes of the previous meeting while Mrs. R. Colquhoun reported on the Penny Sale. A letter was read from the Cobalt and Haileybury nurses, inviting the local nurses to a banquet at Haileybury when Edith Fenton was to be guest speaker.

North Bay

The professional family tree of the R.N.A.O. was outlined by Edith Fenton, public relations secretary, at a meeting of North Bay Chapter. The business session was presided over by I. Black, chairman. It was reported by F. Gasson that $170.46 was cleared on a tea, the money to be used in aid of local projects, including a bursary to assist student nurses.

Sudbury

Last September, His Excellency Bishop H. Dignan of Sault Ste. Marie, accompanied by attending clergy, religious of the Grey Nuns of the Cross who conduct St. Joseph's Hospital, student nurses, and many distinguished guests, blessed the outside structure of St. Elizabeth School of Nursing and residence. Following the ceremonies, a dinner was served to over 200 guests. Open House was held in the afternoon and tea was served by the Women's Auxiliary to over 800 friends.

The new home has an atmosphere of homelike simplicity, enhanced by the varied harmonizing colors of the wall and the well selected furniture. The student curriculum provides excellent professional training. Every need has been met and all facilities are complete.

District 10

Port Arthur

St. Joseph's Hospital

Seventeen members were present at a meeting of the alumnae association when Mrs. C. H. Chase presided. A donation was voted to the Community Chest and Mrs. P. McLeod reported on the successful bake sale. Lunch was served by the following hostesses: N. O'Donnell, Mmes P. McLeod, G. Caron, H. Evans, and M. Leece.

QUEBEC

Montreal

About 300 members of the English Chapter, District 11, A.N.P.Q., attended a general meeting to hear timely information on "Medical and Nursing Aspects of Atomic Warfare." Dr. C. Gardner, surgeon-in-chief, Queen Mary Veterans' Hospital, presented an outline of the organization of medical care in the event of an atomic disaster. E. Pepper, nursing consultant, Civil Defence Health Planning Group, Department of National Health and Welfare, introduced films on the effects of atomic explosion. She then discussed the kind of responsibilities which nurses must prepare to assume.

A. Peverley, district chairman, announced with regret the resignation of D. Goodill as secretary and extended a welcome to K. Brady who will succeed her. A grant of $500 was voted to the Curriculum Committee, A.N.P.Q., to facilitate this important work.

General Hospital

Anna Christie writes from Fairfield Hospital, Melbourne, Australia: "For several months I have been ward sister on a female general ward where convalescent patients are received from the Royal Melbourne Hospital. I am on duty from 7:45 a.m. to 9:00 p.m. four days a week then off for three days. The R.M.H. buildings are new and modern. The infirmary for sick nurses forms part of the hospital, complete with own staff. There are 400 student nurses in the residence.

"The view of the city from the tenth floor is superb. Melbourne is a beautiful city, reaching out for 20 miles in all directions, displaying scenic streets, parks and gardens. Gliding over the city at night, with hundreds of lighted ships in harbor, is an exhilarating experience. Shall arrive in Johannesburg,

S.A., by the end of January for duty at the General Hospital on Klein St."

M. Trueman is studying the Japanese language in Tokyo preparatory to doing public health work under the Church of Christ in Japan.

For the past three years recordings have been made of the carols sung at half past six on Christmas eve. The event gains in popularity yearly.

Best Wishes for the New Year to M.G.H. nurses everywhere from your old School.

McGill School for Graduate Nurses

Fourteen students received certificates and 17 their Bachelor of Nursing degrees at the colorful Founders Day Convocation in October. The school staff held a coffee party at Beatty Hall following the ceremony when families, friends, and teachers honored the graduating students. On the previous evening an informal reunion dinner of the members of the 1950-51 class was held.

This year's students were welcomed to the School by a pleasant Sunday afternoon tea. Guests were welcomed by Geneva Purcell, alumnae president, and Elva Honey, school director.

The following former McGill students have returned to complete their study for the B.N. degree: L. M. Downing, K. C. Feisel, E. H. Felsing, and H. D. Knox.

SHERBROOKE

The annual nurses' dance, held by the Sherbrooke Hospital Alumnae Association, was a social and financial success. Responsible for the preparations were B. Boyd, social convener, Mmes F. Stegmaier, E. Lavallée, and W. Chisholm.

Norma Beattie, a local graduate, has assumed her duties as operating room supervisor, replacing Alfreda (Dearden) Lockley. Miss Beattie, who has taken a course in O.R. technique, at St. Michael's Hospital, Toronto, was O.R. supervisor at Herbert Reddy Memorial Hospital, Montreal, prior to joining the R.C.A.F. Nursing Service. On her discharge she was assistant O.R. supervisor at New England Deaconness Hospital, Boston. Other additions to the staff include Miss Beckwith as clinical instructor and Misses Derrick and Desmisseaux to general staff duty. D. Olson, A. McElrea, and O. Harvey have taken positions at King Edward VII Memorial Hospital, Bermuda.

The hospital would appreciate volunteers to assist at Drs. Silver and Walker's clinics where D. Whitcher is in charge.

SASKATCHEWAN

REGINA

All nurses on hospital staffs should be registered with the S.R.N.A., Lola Wilson, registrar for that association, emphasized in her address to delegates of the Saskatchewan Hospital Association convention held here. Miss Wilson explained that such registration is the only way of assuring that nurses meet the minimum requirements of their profession. Registered nurses rarely get into the difficulties less qualified nurses do, she said. "Registration is a good—although not sure-fire—method of protecting hospitals from incompetents."

Members approved the amalgamation of the institutional and private duty sections of Regina Chapter 7 at a recent meeting. The amalgamation was to be effected for educational purposes. Each section will retain its own chairman and conduct its affairs as previously. Following business, the 50 members enjoyed a musical program arranged by J. Warden.

SASKATOON

City Hospital

The annual tea and bazaar, sponsored by the Student Nurses' Association, was held in October, the 1953-B class successfully managing the function. The convener was D. Evans. The guests were welcomed by Mrs. H. A. Armstrong, director of nursing, and D. Evans, with E. Gillespie, D. Berregaard, and D. Gibson assisting. E. Bean and L. Callander were in charge of the guest book. The bazaar featured home-cooking, candy, fancy work, handicrafts, and sewing. The tea table was presided over by Mmes G. W. Kinsman, E. R. Peterson, F. L. McConnell, S. A. Orchard, A. L. Caldwell, and L. Goluboff. Of special interest was the lace tablecloth, the gift of Mrs. J. E. Porteous, former director of nursing. The door prize was won by Mrs. Gould.

St. Paul's Hospital

Sr. A. Ste. Croix, director of nurses, F. McDonald, educational director, and M. Mackenzie, nursing arts coordinator, attended an institute on "General Study of the School of Nursing Curriculum in Saskatchewan" in Regina. M. Mackenzie and S. Leeper participated in a Civil Defence Course held in Regina.

Students planned a musical recital in honor of St. Cecilia on her feast day when members of the public speaking group presented a debate on "The Emancipation of Women—a Mistake or Not?"

Word Game

Word list for game on Page 9

A—ache, acme, ahem, aper, apron.
B—beach, beak, beam, beamish, beat, beta, betimes, breach, break, broil, brow, brown.
C—cake, came, cameo, camion, camise, cape, caper, cater, cation, chap, chaperon, chat, chemist, chest.
D—dream, droit, drown.
E—each, emit, erotism, ester.
F—flit, flog, floret, flow, flush, fluster.
G—glister, glow, goitre, golf, gore, gown.
H—hack, hames, hams, hate, hems.
I—iota, item, iter.
J—jest, jester, jilt, just.
K—kerb, kern.

L—lime, lion, list, lister, liter, loiter, long, lord, lore, lush, lust, luster.
M—mache, make, maker, mate, mater, meat, mesh, milord, milt, mist, mistake, mister, mite, miter.
N—noise, note.
P—pack, pate, pater, patio, patois, patrol, patron, peach, peak, peat, pert, petrol, preach, prong, prow.
Q—quilt, quit, quite.
R—reach, ream, reap, remit, repack, repay, roil, rote.
S—seme, semi, semite, shack, shaker, shaky, sham, shame, shape, shay, silo, silt, site, smack, smite, stack, stake, stay, steak, steam, stem, step, stern, sterol, stove, stow, streak, stream, strong, strown, suit, suite, suitor.
T—tack, tacky, take, tame, tape, taper, teach, teak, team, tern, time, toil, tolu, tong, tore, torn, town, trow.
U—ultima
W—wolf, word, wore, worn, wort, wrong, wrote.
Y—yams.
Z—zest.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Science Instructor. Post-graduate course in Nursing Education; degree desired. Initial gross salary: $105 bi-weekly plus Cost of Living Bonus. **Nursing Arts Instructor**—nurse experienced in bedside nursing & ward administration with post-graduate course in Teaching & Supervision. Initial gross salary: $99 bi-weekly plus C.O.L. Bonus. **Clinical Instructors (3)**—(a) Pre-clinical students (b) medical (c) surgical. Initial gross salary: $99 bi-weekly plus C.O.L. Bonus. For other perquisites—vacation, illness, pension, etc. & further information—apply Supt. of Nurses, General Hospital, Hamilton, Ont.

Public Health Nurse immediately for No. 9 (Red Deer) Health Unit, Alta. Salary range: $2,160-2,760. Superannuation. 3 wks. annual holiday. Sick leave. Apply Dr. C. G. More, M.O.H., Red Deer, Alta.

Night Supervisor & Nursery Supervisor for 65-bed hospital. Good salary for qualified persons. 8-hr. day, 6-day wk. Apply Catherine Booth Hospital, 4400 Walkley Ave., Montreal 28, Que.

Registered Nurses for modern 10-bed hospital. R.N.A.B.C. schedule, commencing at $200 for B.C. registration. Full maintenance. Private rooms $35. Straight 8-hr. shift. Fare up to $75 refunded after 1 yr. Apply Mrs. Newhouser, Sec., Terrace & District Hospital Ass'n, Terrace, B.C.

General Duty Nurse for modern 24-bed hospital with nurses' home, etc. Salary to start: $165 per mo. with full maintenance. Raise after 3 mos. Apply Matron, Union Hospital, Vanguard, Sask.

General Duty Nurses for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for night duty. Increase at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holiday after 1 yr. service. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Registered Nurses & Licensed Practical Nurses for hospitals & fully modern outpost nursing stations. For further information apply Indian Health Services, Dept. of National Health & Welfare, 522 Dominion Public Bldg., Winnipeg, Man. (Phone 927 100).

Health Nurse, Science Instructor, Head Nurse in Pediatrics, Night Asst. Supervisor—all positions vacant in June at Royal Alexandra Hospital, Edmonton, Alta. Apply Supt. of Nurses.

General Duty Nurses for 90-bed hospital in B.C.'s Cariboo District. Salary: $210 less $45 maintenance in comfortable nurses' home. Fare refunded after 6 mos. service. 44-hr. wk. 28 days holiday after 1 yr. service. Proportionate holidays after 6 mos. All statutory holidays. Progressive town offers wide variety of winter & summer sports. Twice daily plane service to Vancouver. For further information apply Miss G. Gowans, Director of Nursing, Prince George & District Hospital, Prince George, B.C.

Registered Nurses for General Duty in new 60-bed hospital on Lake Erie, 35 miles from Detroit. 8-hr. duty, rotating shifts. Apply District Memorial Hospital, Leamington, Ont.

Residence Nurse immediately. Apply Sec., University of Toronto School of Nursing, 7 Queen's Park, Toronto 5, Ont.

Matron for 30-bed hospital. Salary: $215 per mo. plus board & room. Modern residence. Two doctors in town of 1,400 pop. 6 R.N.'s & 2 Nurses Aides on staff. Write or wire J. H. Moysey, Sec.-Mgr., Union Hospital, Eston, Sask.

General Duty Nurses for Operating Room, Pediatrics & Surgical & Medical Nursing. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

Public Health Nurse for Huron County Health Unit. Salary adjusted as to experience. Car provided or liberal car allowance. Self-contained 3-room apt. available. Apply Dr. R. M. Aldis, M.O.H., Clinton, Ont.

General Duty Nurses for 60-bed hospital. 48-hr. wk. Salary: $150 per mo. with 3 annual increments of $5.00. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Goderich, Ont.

Supt. of Nurses immediately for 60-bed hospital. Apply, giving full particulars, General Hospital, Goderich, Ont.

Night Supervisor, General Duty Nurses, Registered & Grace Maternity Graduates. Apply, stating experience, Supt., Queens General Hospital, Liverpool, N.S.

Pediatric Supervisor, preferably one with certificate in Teaching & Supervision, for 40-bed unit in 450-bed General Hospital. Basic salary: $240 per mo. with yearly increments. 11 statutory holidays. 4 wks. annual vacation. Apply, giving full details, Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Operating Room Nurses (experienced). Personnel policies compatible with recommended policies of New York State Nurses' Association. Apply Director of Nurses, Arnot-Ogden Memorial Hospital, Elmira, New York.

General Duty Nurses for Red Cross Hospital, Yellowknife, N.W.T. Salary: $180 less $30 board & room. Modern conveniences. 8-hr. day, 6-day wk. Air transportation paid from Edmonton. After 1 yr., 3-wk. paid vacation plus return transportation to Edmonton. The place for a nurse who likes activity. Apply to Business Mgr.

Graduate Nurses. Salary: $210 per mo. Apply. Supt., Warren Hospital, Warren, Minnesota.

Graduate Nurses for General Duty (2) at once for 36-bed hospital. Salary: $145 per mo. with full maintenance, increasing to $150 end of 6 mos. 8-hr. day., straight shift. 1 mo. holiday with pay end of 1 yr. Sick pay. Progressive growing town of 2,500 on C.P.R. main line & Trans-Canada highway. Community, social & recreational facilities. Apply, stating qualifications & experience, Mr. H. J. Peddie, Sec.-Treas., Municipal Hospital, Brooks, Alta.

Registered Nurses (2) for General Duty in 25-bed General Hospital. 8-hr. duty. 44-hr. wk. 2 wks. rotation. Salary: $155 per mo. plus full maintenance. Apply Supt., Louise Marshall Hospital, Mt. Forest, Ont.

General Duty & Operating Room Nurses for new small hospital in San Joaquin Valley, Calif. Hospital well equipped & town offers all advantages & pleasantness of life in small community within easy travel distance of Oakland & San Francisco. 40-hr. wk. Minimum starting salary: $240. Apply Administrator, Community Memorial Hospital, Tracy, California.

Matron for 18-bed hospital. Salary: $250 less maintenance. **General Duty Nurses** for southern interior B.C. hospital. Salary: $200 less maintenance plus $5.00 night duty. Annual increment. 44-hr. wk. 3 rotating shifts. 4 wks. holiday with full salary. Fare up to $50 refunded after 1 yr. service. **Operating Room Nurse.** Salary: $210. Balance of terms of employment as above. Apply Creston Valley Hospital Association, Box 30, Creston, B.C.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

Science Instructor (1) & Nursing Arts Instructor (1) for new hospital to be opened 1952. Salaries open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. **Operating Room Supervisor.** Starting salary: $250 per mo. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. **Pediatric Supervisor** (teaching & administrative). $225. **Asst. Night Supervisor.** Rotating 3-11, 11-7. $225-235 depending on qualifications. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

General Duty Graduate Nurses for new, well equipped 60-bed acute General Hospital in heart of famous logging & fishing industries on B.C. coast. Salary: $185 per mo. less $25 for board, room, laundry. 4 wks. annual vacation plus 10 statutory holidays. Sick time. Fare advanced if desired. Apply Supt. of Nurses, St. George's Hospital, Alert Bay, B.C.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

Registered Nurses (2) for General Duty in new modern 20-bed hospital. Salary: $160 per mo. & full maintenance. Duties to commence immediately. Apply P. J. Rasmussen, Sec., Union Hospital, Climax, Sask.

Staff Nurses—all Depts. Optional—44- or 40-hr. wk. in all depts. Remuneration accordingly. 8-hr. day. $11, day duty; $12 per day, afternoon or night duty. 25 miles north of Detroit. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for General Staff (2) in 21-bed hospital. Salary: $140 per mo. Room, board, uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Also **Nurses' Aide.** Apply Supt. of Nurses, General Hospital, Espanola, Ontario.

General Duty Nurses for small hospital. Salary—Registered Nurses, $160 per mo. plus full maintenance; others according to qualifications. Apply Supt., Lady Minto Hospital, Cochrane, Ontario.

Operating Room—General Staff Nurses. Gross monthly salary: $193.50 ($210.50 less perquisites, 2 meals & laundry, $25.50). 8-hr. day, 44-hr. wk. Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

Nursing Arts Instructor & General Duty Nurses for 200-bed hospital. Salaries $195 & $175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, British Columbia.

Registered or Graduate Nurses (2) for modern 20-bed hospital. Salary: $180 & $170 per mo. gross. Usual holiday time & sick leave. Apply E. W. Groshong, Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

General Staff Nurses for 60-bed Pediatric-Orthopedic Hospital. For information apply Director, Shriners' Hospitals for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.

Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

Directrice Nationale, Services du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada

Supt. of Nurses by Feb. 1 for 150-bed General Hospital—75 student nurses. Gross salary commencing at $290 per mo. plus pension plan. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications, experience & age, Administrator, General Hospital, Chatham, Ont.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Operating Room Supervisor. Salary: $210 per mo. gross. **General Duty Nurses.** Salary: $165-175 per mo. gross depending on experience. **Night Supervisor.** Salary: $210 per mo. gross. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. made for board & room. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Laboratory Technician. Gross salary: $170 per mo. 177-bed hospital. For full particulars apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Registered Nurses (8). Starting salary equivalent to Calif. State Nursing Ass'n standards. Comfortable modern nurses' home available—$10 per mo. After 1 yr. 23 vacation days. Cumulative sick leave. 11 holidays yearly. Rotation shift if desired. Vacancies all nursing services—Surgery Nurse & Obstetrical Nurse supervisory; Teaching Supervisor. Apply Director of Nurses, County General Hospital, Tulare, California.

Registered Nurses for General Duty for small General Hospital. Salary: $125 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert, B.C. Salary for General Duty, $225 per mo. plus yearly increases. Room, board, laundry charged at $30 per mo. Applications from nurses with supervisory experience in tuberculosis work will be considered for Charge Nurse positions at higher rates. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

General Duty Nurses. Salary: $163.40 (one sixty-three dollars & forty cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ontario.

Graduate Nurses (2) for General Duty immediately. Salary: $200 with annual increment of $5.00. Full maintenance, $40. 44-hr. wk. 28 days holiday after 1 yr. service. Sick leave, 1½ days per mo. Fare advanced if required. Apply Matron, Slocan Community Hospital, New Denver, B.C.

Registered Nurses with Public Health Training & experience, preferably generalized. Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 112 College St., Toronto 2, Ont.

General Duty Nurses for Trail-Tadanac Hospital, Trail, B.C. Gross salary: $200 per mo. For full particulars apply Administrator, Miss Vera B. Eidt.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $175-213 plus $20 C.O.L. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for General Staff for Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, Smiths Falls, St. Thomas, Toronto, Whitby, Woodstock. Gross salary: $2,260 per annum with maximum salary of $2,660, less perquisites ($26.50 for room, board, laundry). Cumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

Registered Nurses for 60-bed General Hospital. Commencing salary: $150 per mo. plus full maintenance. 44-hr. wk. 3 wks. vacation per yr. & statutory holidays. Apply Supt., Public Hospital, Smiths Falls, Ont.

Graduate Nurses for Staff Duty—Medical, surgical & obstetrical services. Beginning salary: $250 per mo. Increase every 6 mos.—Maximum $270. $10 additional per mo. for operating or birthroom service. Extra remuneration for afternoon & night duty. 5-day, 40-hr. wk. Apply Personnel Dept., Florence Crittenton Hospital, 1550 Tuxedo Ave., Detroit 6, Michigan.

Registered Nurses for General Duty in small active hospital in Central Ontario. Good salary. 8-hr. duty, rotating shifts. 6-day wk. 12 days sick leave, 2 wks. vacation with pay & 7 statutory holidays. Apply Supt., General Hospital, Palmerston, Ont.

General Duty Nurse immediately for 17-bed hospital. Conditions of work & salary as recommended by S.R.N.A. New separate nurses' residence. Excellent transportation to Regina, Saskatoon & Moose Jaw—6 buses & 4 trains daily. Apply Matron, Union Hospital, Davidson, Saskatchewan.

Obstetrical Teaching Supervisor for 58-bed dept. (800-bed hospital). Salary open. Experience & advanced preparation required. Duties include teaching & supervision of nursing care. Living in optional. Good working conditions. Details on request. Apply Supt. of Nurses, General Hospital, Regina, Sask.

Scrub Nurses for Operating Room for General Hospital, Regina, Sask. Salary commensurate with preparation & experience. Apply Supt. of Nurses.

Graduate Nurses—Vancouver General Hospital invites immediate inquiries for **Staff Vacancies.** Commencing Jan. 1 salaries will be $222 as a minimum & $258 as a maximum per mo. plus shift differentials for evening & night duty. Employee benefits include: 44-hr. wk.; 11 public holidays; 4 wks. vacation; 1½ days per mo. cumulative sick leave; pension plan if under age 35. Acceptable qualifications for registration in B.C. necessary. Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

Director of Nursing for medium-sized hospital with Nurses Training School. University training desirable but not necessary. Full maintenance & private apt. provided. Personal interview to be arranged immediately following receipt of application. Write, outlining qualifications & salary expected, Supt., Memorial Hospital, St. Thomas, Ont.

Graduate Nurses for General Duty on Medical, Surgical & Obstetrical floors in 85-bed hospital, located near Chicago. Also **Surgical Supervisor & Central Supply Supervisor.** Starting salary: $255 with afternoon bonus $30 & night bonus $20. Apply Personnel Director, Highland Park Hospital, Highland Park, Illinois.

WANTED •

600-BED HOSPITAL, WITH ACTIVE SURGICAL SERVICE, REQUIRES AN

Operating Room Supervisor. *Staff consists of:* Assistants, General Duty Graduates, Students and Auxiliary Personnel. Salary depends on experience and qualifications. Excellent Personnel Policies.

For further information write:

Director of Nursing, Victoria Hospital, London, Ontario.

General Duty Nurses. Basic monthly salary: $150 plus full maintenance. Also **Operating Room Supervisor** for well equipped 70-bed hospital. All graduate staff. Apply Supt. of Nurses, Douglas Memorial Hospital, Fort Erie, Ont. (10 min. from downtown Buffalo).

Registered Nurse with Operating Room experience wishing to learn matronship & be able to take over Matron's position in near future. Matron's salary: $200 per mo. with increases. Applicants must have had at least 3-5 yrs. nursing experience. Apply Herbert-Morse Union Hospital, Herbert, Sask.

Asst. Supt. for 60-bed General Hospital. Also **Operating Room Supervisor.** Salary: $180-200 plus maintenance for 44-hr. wk. Apply Supt., Public Hospital, Smiths Falls, Ont.

Dietitian for 60-bed General Hospital. Salary open. Apply Supt., Public Hospital, Smiths Falls, Ont.

Nurses. Salary above C.S.N.A. wage schedule. Annual leave. Sick leave. 11 holidays. 40-hr. wk. Apply Administrator, Municipal Hospital, 310 S. Floral St., Visalia, California.

Graduate Nurses for 200-bed Tuberculosis Sanatorium at Nanaimo, Vancouver Island, B.C. Services include major surgery, orthopedic & pediatric nursing. Salary: $180 per mo. for recent graduates; $203 for nurses with 3 yrs. experience since graduation with yearly increments. Single room, board & laundry provided for $30 per mo. Hospital has beautiful location, excellent climate & comfortable quarters. Apply, stating qualifications & experience, Matron, Nanaimo Indian Hospital, Nanaimo, B.C.

National Health Week

February 3 to 9

National Health Week is dedicated to making Canadians ever more aware of the value of good health to themselves, to their families, and to their communities. It is an annual observance that depends for its success upon the voluntary support of every responsible citizen. Health deserves year-round attention but the extra boost of this concentrated campaign is needed to keep Canadians on the alert. Will you help?

DEPARTMENT OF HEALTH
NEWFOUNDLAND

The Newfoundland Dept. of Health

requires

Registered Nurses for Staff Duty

IN 30-BED HOSPITALS

• Complete maintenance & uniforms are provided, as well as Cost of Living Bonuses & 24 working days annual vacation. Transportation expenses to Newfoundland are paid for a one-year contract. Return expenses are also paid for two-year contracts.

For further particulars apply to:

The Director of Departmental Nurses, Department of Health, St. John's, Newfoundland, Canada.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, Que.

President..... Miss Helen G. McArthur, Canadian Red Cross Society, 95 Wellesley St. E. Toronto 5, Ont.

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New Brunswick..... Miss Muriel Hunter, Provincial Health Dept., Fredericton.

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